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GOALS IN THERAPY

A ROUND TABLE DISCUSSION

HAROLD KELMAN, MODERATOR

INHERENT in the topic of this round table, "Goals in Therapy," are the essence and reason for our being. For our being human and for our human being. Our goals in therapy determine the what and how of our being healers and helpers. In asserting what and how we are helping healing and helping growing, we are also asking and answering healing what, helping for what, with what and toward what end.

My opening words, poetic in form, allusive in feeling and maybe mystifying in effect, nonetheless state the big questions which I feel all of us are attempting to answer, whatever our particular interest, private persuasion or theoretical preferences.

To restate what I have just said in more formalistic and literal language: goals in therapy may be limited or extensive, changing in either direction according to the needs, possibilities, and wishes of patient and physician. Relief from a depression through electro-shock therapy or lessening of tension by thorazine or reserpine may be the immediate, limited goals, with or without the goal of concomitant and/or subsequent psychotherapy.

Psychotherapeutic goals also vary in kind and degree. Efforts may be directed toward symptom removal—e.g., a phobia—or toward amelioration of a syndrome, such as a schizophrenic panic. The goal might be to help with a specific problem, such as a decision to marry, whether or not to break up an important business relationship, or to aid in resolving a work inhibition. Such goals, as well as others, might be relief, amelioration, social rehabilitation, adjustment or problem resolution.

The fulfillment of more extensive goals in therapy generally require longer and more intensive periods of therapy to effect a significant degree of basic personality change. Such goals in therapy imply the bringing about of a major shift in the individual's psychic economy. Where previously most of his energies were manifested in sick ways of existing, they now would be invested predominantly in healthier ways of living. The goals defined and realizable in such therapeutic venturies are premised on varying philosophies and theories regarding the nature of human beings and on the techniques implementing such extensive personality reorganization.

In starting out poetically and continuing literally I have attempted to concretize a viewpoint which I have developed in various places. It is that life and living have poetic and prose aspects, and that theories of human nature and techniques to aid

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These papers were delivered at a Round Table Discussion at the Annual Meeting of the American Psychiatric Association in Atlantic City, New Jersey, on May 12, 1955. Harold Kelman, M.D., is dean of the American Institute for Psychoanalysis. Oskar Diethelm, M.D., is professor of psychiatry, Cornell University Medical College. Elizabeth Kilpatrick, M.D., is a member of the American Institute for Psychoanalysis. Nathan W. Ackerman, M.D., is associate clinical professor of psychiatry, Columbia University. Frederick A. Weiss, M.D., is a member of the Faculty Council of the American Institute for Psychoanalysis. Rudolf Dreikurs, M.D., is professor of psychiatry, Chicago Medical School.

human growing can be more effective operating with concepts and tools that unify the aesthetic and the theoretic. In short, they are holistic and are applicable to the physical and psychological, the individual and the environmental—to all aspects of the total human situation in therapy and in life. Also it is essential that these concepts be of a process nature in keeping with the on-goingness of living. In accord with such a viewpoint, goals in therapy must likewise represent a unification of the allegorical and the abstract. Since the notion of goals often unwittingly carries and supports an emphasis on absolutes, the final, the static and end points "out there," I believe it helps to feel and speak in terms of objectives in the immediate reality which is objectively before us and subjectively felt. The immediate reality, the here and now, is the only reality we can ever know and feel. It is the allwhere and the everywhen. I feel our continuing objective in therapy is to help a patient feel his wholeness—his whatness and thereby his howness here and now, from moment to moment, while we as therapist are doing likewise with reference to ourselves. The multitudinous whats in the moment, implicit and explicit, describable and inferred, constitute the how, and extended in time are the pattern and the poetry of living.

With the continuing objective of helping a patient experience more and more aspects of his wholeness, his awareness will be expanding, his acquired problems will be resolving and he will be being freer to find and choose his own ideals and values with the awareness that they are aspirations never realizable. Also he will become less driven to seek relief from anxiety and conflict, and to dissipate his tensions in wasteful ways. He will become more spontaneously able to embody and contain his anxieties, conflicts and tensions, accepting and recognizing them as resources of energies available for productive living. For the human being who is saying yes to living has an alive awareness that tensions, anxieties and conflicts, aspirations and struggles are essential to self-creating and creating his world. As he and his therapist know this they will feel with Keats that "a man's life of any worth is a continual allegory, and very few eyes can see the mystery of his life —a life like the Scriptures, figurative." "Shakespeare led a life of allegory; his works are the comments on it." And what I have inadequately said—in so many words —Keats says with the gift of the poet in so few when he gives us his feeling of allegory. It is, he says, "that inward, unseen thrust and rudder, that deeper determinism, that patterning agency, by which if it is to happen at all, the merely multitudinous can take on shape and meaning."

As patient and therapist feel more the rhythm of life's "unseen thrust and rudder" they will be realizing, with Einstein, another objective in healing and helping, that "the true value of a human being is determined primarily by the measure and the sense in which he has attained liberation from the self."

Oskar Diethelm

The topic, "Goals in Therapy," implies consideration of therapy in its broadest terms and not merely goals in psychotherapy. We may accept psychotherapy as the most important tool in psychiatric treatment, but even this statement has to be limited if we consider the goals of treatment in disorders due to brain disease, such as general paresis or diseases of aging.

In literature there has been discussion in recent years of goals limited to psychotherapy, and there has been recognition and wide acceptance of the need to reevaluate these goals as one progresses with the treatment of an individual patient. Dependent on the therapist's personal philosophy and his theoretical background, and on current cultural attitudes and influences, goals will be formulated differently. This fact becomes obvious when one pursues the literature of

the past half century. It even can be seen in publications of the preceding century and in earlier periods if one studies carefully whatever methods of treatment, including psychotherapy, were presented in literature.

The goals of psychotherapy, as shown in recent literature, are varied and illustrate the influence of the personal philosophy and theoretical background of the authors. A few examples will illustrate this point. With the acceptance of the treatment of the whole personality, less value has been attached to the disappearance of symptoms. Instead of freedom from anxiety, which is still the goal for many psychiatrists, the ability to bear this painful experience is stressed by others. A similar change has become obvious in the evaluation of frustration and aggressive impulses. Increasingly one tries to make the patient aware of his limitations and on such a basis to bear frustration, to accept one's hostility and be able to deal constructively with one's aggressive impulses, and to recognize and tolerate one's weaknesses. The importance of insight has been considered by many authors, and it is now accepted that the goal of therapy should not be to give insight into the dynamics but to provide understanding and ability to deal with oneself and with reality situations. Authors who seem to believe in the philosophy of will, stress the need for self-reliance. Because of the general sociological and cultural appreciation of the relationship of the individual to other individuals and to society, the goal of interpersonal adjustments and adjustment to the community has become increasingly stressed. There are many other philosophical attitudes and theories found in the psychiatric literature of the last fifty years. The influence of most of them has been restricted to the individual psychiatrist and a few of his students, and I shall therefore not take the time to dwell on them.

In my own thinking and in my development of the broad aspects of dynamic treatment, I have stressed various goals. I would first mention the possibility of self-dependence and ability and willingness to be part of the group and community in which we live, developing in this way a feeling of security. It also seems to me important that one learn to recognize and tolerate one's emotions and their somatic and subjective expression as well as the meaning of the emotion to oneself. Emotions are of the greatest value in guiding us to healthy life, and we should take emotions constantly as an indicator of underlying dynamic forces. By recognizing these forces, or by knowing at least that certain forces must be present, we are more or less able to direct ourselves. It is therefore less important for a patient's symptoms to disappear than that he learn how to deal with them and to use correlating emotions as a guide. Insight into the general dynamics of one's past is desirable and the outcome of treatment should therefore be a uniform, although frequently vague, picture of the dynamics in our life, a picture in which gaps may occur, but which are not disturbing to the patient and do not produce in him an anxious need to look for further explanations.

The results of treatment, and whether we have been able to reach the attempted goal or should change our expectancy of goal, can be recognized by the patient's adjustment to life, by his activities, and by his achieving a healthy repression and forgetting. Treatment is a continuous reintegration with forgetting, and in successful treatment the patient should not be able to give us detailed information about psychotherapy or have a need to remember details of the treatment.

It is necessary that these principles be applied to every kind of therapy, not merely to psychotherapy. The existing psychopathology, which includes the type and strength of all kinds of dynamic factors and the patient's achievements and potentialities, will indicate the goals for which one should strive. It is important that one should guard against injecting one's own values. This warning is most frequently disregarded and leads to pushing a patient to too high a goal or rejecting him as a therapeutic failure. One's personal concept of what constitutes a satisfactory life, or happiness, should not unduly influence one's therapeutic expectations. A frequently

occurring illustration is seen in a psychiatrist's stress on keeping a patient in the community and preventing admission to a psychiatric hospital. Another example is the emphasis on work and self-support. This goal is desirable but in many psychopathological conditions unattainable. The goal of therapy must then be adjusted. In some patients the goals may include an active life in the community, in others a restricted life in the community. Some patients need to retreat from the strain of the community and remain in a hospital, which presents a prolonged or permanent asylum. The goal should then be to have the patient participate in a planned life which corresponds to that which in our culture seems essential—a balance of work and recreation and suitable attention to one's physical and psychological needs.

The point that a permanent stay in a psychiatric hospital may be a therapeutic goal deserves further discussion. From a practical point of view there is no doubt that a large number of patients will not be able to live in the community, but this outcome is usually considered a poor therapeutic result. This attitude is an example of the physician's injecting his personal values into the goal evaluation. We can agree that restriction of freedom presents a most distressing way of living. There are, however, well-adjusted persons who prefer more or less far-reaching restrictions to full responsibility for all their actions, or who wish to lead a life away from certain stresses of current life. Accepting prolonged or even permanent stay in a psychiatric hospital community, a physician should plan for the patient a life which provides for his social needs. Such planning for life in a hospital must take into consideration activity and rest, individual desires for privacy and social contact, satisfying ethical and esthetic needs. This life is dynamic and never static. In some patients a satisfactory life can be achieved in the hospital, especially in paranoic patients. In others, the goal is to prevent the patient from yielding too much and prevent him from living in unhappy defeatism and loneliness, as found in many deteriorated schizophrenic patients. In general, our knowledge of the dynamics of, and our experience with, deteriorated schizophrenic patients is unfortunately so limited that we are not able as yet to plan for correct therapeutic goals.

Goals will change during prolonged treatment and can therefore be considered only temporary, dependent on a nonpredictable future. The psychiatrist must be willing to accept the unforeseeable need for the formulation of new goals which modify, or even change completely, the goals already undertaken. Such a therapeutic reformulation should not be expressed as a raising or lowering of goals but as recognizing the necessity to find different goals.

Guidance and support for years or for a lifetime may often be the best obtainable goal. In other conditions, treatment should be terminated by greatly modifying the originally conceived goals which proved to be unattainable.

It is essential that a psychiatrist be aware of his general therapeutic attitude and formulate specific goals. A good knowledge of psychopathology will force him to modify or change goals and enable him to help the patient to find the best possible solution for his difficulties. The need for formulating therapeutic goals, with clear understanding of the underlying principles, is present in all types of psychiatric treatment, whether applied to hospitalized or ambulatory patients, suffering from acute or chronic conditions.

ELIZABETH KILPATRICK

Each psychiatrist's goals of therapy are determined by his particular concept of a healthy human being, and by what he considers the essential characteristics of a neurosis. His approximation to his goals will depend on his scientific knowledge, his ability to utilize that knowledge in therapy, and the severity of the patient's neurosis. In this discussion I am confining myself to goals of therapy for the neurotic patient in psychoanalytic therapy.

My concept of the innate qualities of a

human being is implied in the theory of human motivation, expounded by many scientists and used by Horney as the basis for her theory of neurosis—namely, that man is born with the potentials and the incentives to fulfill himself, that man's innate incentives are for holistic growth in the direction of reaching for a deeper meaning in life, for closer relatedness, for deeper feeling, for greater understanding of self, of others and of the universe.

In so far as development takes place naturally, the individual is healthy. He draws at will on all his rich potentials. He knows the joy of spontaneity. He is well organized, free moving, and inwardly confident. He is ever becoming a mature human being. He derives deep satisfaction from moving toward goals he may never achieve. This process toward self-fulfillment is continuous from birth to death, unless interfered with by pathological processes—one of which is *neurosis*.

The soil for neurosis is an environment antithetic to holistic growth for the young child. The child becomes uncertain and anxious. He grows—but his growth is distorted. His only method of dealing with human contacts is to devise ways which are safe for him since they alleviate anxiety. This procedure reduces his spontaneity.

Gradually he builds up a defensive structure. This process interferes more and more with the innate process of self-fulfillment. Such a way of life is motivated first by a reality dangerous to the child, but it gradually becomes self-perpetuated and motivated by unconscious drives for safety. So, the neurotic character structure replaces the natural character structure.

A characteristic of the neurotic patient is rigidity. His growth is restricted by unconscious drives to dominate others by power or dependency, or toward isolating himself. He feels inwardly deprived and insecure. His spontaneous feelings have been replaced by temporary elation when his system to allay anxiety works, and by depression or panic when it does not. His need for safety limits his ability to get into new situations and to reach for new experiences. He is not free to draw on his innate potentials.

Our goal of therapy is to help the neurotic patient to retrieve himself from the process toward self-obliteration and to help him to regain his spontaneous incentives for self-realization.

The outlook for therapy is optimistic. Neurosis is an acquired disorder and the patient unwittingly structured it. The neurotic process never entirely paralyzes the innate constructiveness in the patient. A healthy core remains which can be utilized in therapy. We see evidences of striving for a constructive way of life in the patient's attempts at relatedness, even though his terms are too difficult for the average person to accept. He says, "I want to belong; I want to be loved," but at the same time indicates, "I hate everybody." We see constructiveness in his wish to be more comfortable, in his seeking help from a therapist even though he expects change as if by magic. He demonstrates feelings toward other living things, perhaps only plants or animals. We see healthy striving in such accomplishments as holding a job, or belonging to a group—even though the incentives may be largely neurotic.

At the beginning of therapy the patient is unaware of or rejects these evidences of constructiveness. An important therapeutic goal is to help the patient identify what remains of his incentives toward healthy growth, help him to experience them, support them, and utilize them in the cooperative work with the therapist against the neurosis.

Another therapeutic goal is the resolution of the neurotic structure. This is a step-by-step process. I shall identify the steps as the immediate goals in therapy. They are accomplished more or less simultaneously. Throughout the process the therapist is attentive to every mood, word and gesture of the patient. He provides an atmosphere of relaxation and acceptance. Explicity and implicity he conveys his interest and hopefulness. Through his desire and effort to understand the patient, he helps the patient to become involved in himself.

A continuous goal throughout therapy is

that of increasing self-awareness. To the extent that our patient is neurotic he experiences himself as existing only in relation to others. As he begins therapy, he presents his problems as due to circumstances outside himself: "My job situation is bad." Or he may see himself in another: "My wife upsets me. She is so muddled! She avoids facing facts! She is weak-kneed."

In ensuing sessions, he projects his problems, one after another, on his associates, relatives and his therapist. As these projections are examined in the supportive treatment situation, the patient becomes aware of an "I"—an actual self he begins to recognize as having a part in everything that happens to him. Eventually he becomes aware of how little he has dealt with reality and that his activities are determined by drives within himself.

The next step is to experience the realization that he has shown little control over these inner drives. As he moves slowly to another goal—self-acceptance—he tests the therapist's attitudes and values and tries to bargain with the therapist before emotionally experiencing and accepting what he is becoming aware of about himself. He is then able to assume some responsibility for himself as an individual with problems to be worked on. This is the incentive which keeps a patient in therapy. He accepts himself as not free-moving, not driven by other people, but coerced by his own compulsive drives. He has blamed significant people in the past as well as the present for his failures, or he has accepted the significant people as perfect and blamed himself. Through understanding and experiencing emotionally the function of these drives in maintaining the neurotic structure and in alienating him from his spontaneous healthy desires, he begins to feel free. He reaches the place where he accepts himself and others realistically, appreciating similarities and differences.

The neurotic patient rarely experiences the feeling that he can do well. Frequently he attributes his successes, as well as his failures, to the outside world: "Anybody could do it," "The examinations were easy." He may express the feeling that the analyst is entirely responsible for his progress in analysis. Accepting his share in what happens to him gradually gives him a feeling of solidarity and status as a human being. The realization of this vital self comes gradually, but is frequently precipitated through a comment by the therapist, or an inner voice seeming to say, "Why don't you do something?" Or through fantasies or dreams. A very alienated patient first became aware of her whole self in an anxiety dream where, as her actual self, she was frustrated at every stage of a journey. Toward the end of the dream she met a tiny figure dancing along the road. It was not a human being, not an animal. It had no face, yet it seemed to be smiling. It could not talk, but there was an air of happiness about it. She joined it in play and in the dream her anxiety left. On awakening, the creature reminded her of an embryo.

During her next treatment session she recalled an abortion she had had years before. She remembered how stolidly she had gone through the experience: "I realize now I was very sad at giving up my baby, but I had learned it hurts too much to feel about anything. I pretended nothing hurt. It's a long time since I have even felt hurt." By receiving the intuitive support of the analyst in her efforts, she brought in many examples where she had killed her spontaneous feelings. Through patient effort and time she became able to experience the consequences of this on her whole life. She was gradually able to reach the point where she could trust her real feelings, thus making available more of her potentials.

The goal of self-knowledge is deeper and deeper information about oneself. Here, as always, the therapist is tolerant and accepting as he encourages the patient to experience fully the feelings and attitudes which he is becoming aware of. The therapist adjusts to the patient's pace and to his tolerance for anxiety as they work through the intricate meshes of the neurosis. This is an exquisitely co-operative procedure. Temporarily the therapist is the recipient of hostile or tender feelings. Temporarily he serves as the object of the patient's projected feelings of self-pride or self-contempt.

Always, for the patient, he is a combination of himself and one or another symbolic figure. As analysis progresses, the symbolism becomes less.

The goal of self-knowledge is a never-ending search. It discloses hitherto unavailable material from areas over the whole life span. Conflicts between neurotic trends, and between neurotic trends and spontaneity, become available for the work of resolution. As the magnitude and complexity of life forces are felt, the patient begins to accept relatedness to parts of himself hitherto unknown. He begins also to experience his fellow men more holistically. He reduces his demands on himself and others. Living then becomes a pleasant experience, as he envisions himself as part of a never-ending evolution. Thus he increases his inner and outer security and further weakens the neurotic structure. The inertia toward work, or the driven need to work, is replaced by satisfaction in working toward increased creativity and productivity.

The goal of self-evaluation is an intellectual and emotional experience which leads to a realistic acceptance of limitations, as well as possibilities. As a result the patient stands more firmly for himself and strives more earnestly toward self-realization. As each patient reaches the place where he can honestly appraise himself, he is able to assimilate evaluations of himself by others.

Further changes which indicate that the goals of health have been achieved are the whole of oneself moving together, better physical health, increase in substantiality, and new horizons opening up. Interpersonal relations improve as the neurotic need to bend nature, time and people diminishes. Sexual relations become a pleasure instead of a means for relieving anxiety. The individual feels a relatedness to the world. He becomes free to love or hate, to have values and to feel free to strive toward their support.

In order to meet the stringent demands of his work, the therapist must aspire to the best possible integration. An essential goal in therapy for both therapist and patient is to arrive at the place where they can continue acquiring deeper self-knowledge and remain flexible to change in a changing world. The patient has reached the stage in therapy where he can do this when anxiety is no longer a block but an incentive to further work. Then his own attitude toward himself is as tolerant, patient and searching as the therapist's has been throughout analysis. He has reached the point where he can live well by drawing on the constructiveness in himself and in the world.

Nathan W. Ackerman

The single, all-encompassing goal of psychotherapy is cure. But, what is a cure in psychotherapy? In confronting this challenge, we must be concerned with several questions: the multiple meanings of the term "cure"; the relations of cure to our changing conception of emotional illness; partial cure, complete cure, the quality of cure; the proof of cure, the relations of cure to the specific illness and person being treated; and finally, the relations of cure to the nature of the curing process itself—the dynamics of the psychotherapeutic relationship.

At the present stage, it is safe to assume that standards for cure, the relations of cure to illness and to the curing process, are by no means uniform. In these respects, there are in our day wide divergences of orientation as between the various schools of psychotherapy, and among individual therapists themselves. In one sense, it ought to come as no surprise that each therapist evolves a relatively personal set of criteria for the goals of therapy and the signs of cure. From one point of view, this perhaps will always be the case; from another, it reflects a present state of affairs which is by no means ideal. In so far as psychotherapy is a healing art, which expresses the therapist's unique use of his personal talents in the curative role, there must always be

striking variations from one therapist to the next in the practice of this art, and in the corresponding judgments of the attainment of cure. Going one step further, the therapist's creativity as an artist will achieve a varying expression in accordance with the unique interpersonal stimuli by which he is confronted in his relation with each of his patients. In consequence, the form of his art, and the convictions of cure will be somewhat different for the same therapist with each of a series of patients. In other words, the final portrait must always be molded both by the particular patient who sits as a model and the gifts of the particular artist. Psychotherapy as the practice of an art is highly personal, cannot and perhaps should not be reduced to a stereotype.

However, that component of psychotherapy which is the healing art cannot by itself go very far, with those rare exceptions of miracles wrought by genuises, unless it is solidly buttressed by a foundation of scientific knowledge of personality, psychopathology, interpersonal relations, and the dynamics of therapeutic process. In principle, the psychotherapist labors under a critical handicap unless his talent rests on a secure feeling of scientific training, experience and wisdom. Since a scientific rationale for the practice of psychotherapy is sorely needed, we must continuously try to objectify the issues which are pertinent to the establishment of goals of therapy, and definitions of cure and the curing process.

The fate of any psychotherapeutic undertaking is influenced by at least four factors: the character of the patient, the character of the therapist, the unique features of emotional communication between them, and the impingement of environmental forces on both persons and what goes on between them.

Today, of necessity, any discussion of these issues must be incomplete, since our understanding of cure and the curing process reflects the same lag as currently prevails in our changing conception of mental and emotional illness and its causation. The definitions of goals of therapy, cure and methods of therapy must inevitably mirror these changing conceptions.

The mentally ill person has at various times in history been thought to be a demon, a witch, a sacred prophet, a person cursed with a hereditary taint or an organic defect of the brain and nervous system; more recently, as a person disabled by a functional disorder of individual personality, or a distortion in interpersonal adaptation.

Against this background, present hypotheses concerning cure and the curing process must be conceived as tentative and provisional. With this in mind, we shall consider here the multiple meanings of cure, the manifestations of cure, the relations of cure to current conceptions of mental illness and mental health, and finally, the relations of means to ends—namely, the correspondence of cure to the curing process itself.

The term "cure" implies first the therapeutic removal of symptoms, those specific signs of disordered functioning which characterize a particular illness. For some therapists, this constitutes the sole meaning of cure; it is conceived as a significant result, sufficient unto itself. Perhaps for certain forms of mental illness, this outcome is good enough. For many therapists, however, and for a great variety of disturbances of mental health, this first meaning of cure is too limiting. The concept of cure carries other meanings—among them, the strengthening of the personality so that the patient may not again fall ill. In this context, it is expected that the process of cure will provide some degree of immunization against a further invasion of illness. Still another meaning of cure is contained in the notion that the personality of the patient must have undergone a basic change, which signifies not only increased adaptive strength and a capacity for resistance to illness, but, in a positive sense, that the individual is now able to realize his potential, to capitalize on his personal resources, so as to feel free, happy, to satisfy personal needs and be an efficient, productive person. Finally, cure also has the meaning that the individual, freed of crippling anxieties, can now unfold his capacity to love others, for sharing with them both pleasure and responsibility, and can experience the full gamut of satisfaction in making a positive contribution to

the welfare of family, friends, and community.

In this broader scheme, the goals of therapy and the connotations of cure constitute a hierarchy of meanings, which may be applied with flexibility and discrimination to a wide assortment of illnesses and psychotherapeutic undertakings. In some, it may make sense to rest content with a lesser cure; in others it is fitting and right that we aspire to a more complete and superior quality of cure.

Then comes the question, how do we know? What in any given case constitutes the proof of cure? The challenge here is to build a set of criteria by which we may appropriately test the adequacy of cure in these several hierarchical meanings. The first criterion is the easiest, namely, the evidence for the disappearance of structured psychopathological symptoms. This is certainly basic to cure, and the least equivocal criterion. However, as soon as we move from here to the question of evidence of the strengthening of personality and immunization against recurrent illness, we enter upon less sure ground; the standards grow hazy and differences among therapists mount. Some speak vaguely of the signs of "ego-strengthening," and increased "maturity" and stability. Others erect more stringent and specific criteria which pertain to favorable directions of change in anxiety response, ways of coping with conflict, control of emotion and impulse, defense operations, affectivity, self-esteem, interpersonal relations and reality perception. Finally, if we inspect those criteria which demonstrate increased capacity for self-fulfillment, and healthier interpersonal relations, we discover almost as much diversity among therapists as there are therapists themselves.

Some of the reasons for this are clear. As we move away from the traditionally narrow concern with the individual and the internal economy of personality to interpersonal adaptation, and the relations of individual to society, our scientific knowledge becomes progressively less precise, and we enter into that no-man's land which is the border area of the relation of values to mental health. As soon as we think of cure not merely as the absence of mental disease, but in positive terms of healthy emotional living within the self and in human relations, there is no escape from the confrontation of values. Values have to do with the search for meaning in life. Meaning is not to be found in the isolated individual; for one who walls himself off from other humans, life becomes more and more empty; meaning is lost. The meaning of life can be discovered only in the alignment of one's conception of self with the significant relations with others. Values are derivatives of social relations, and serve as guideposts for social action. They reflect basic life attitudes, ideals and motivations upon which we base our actions toward desired goals. They provide points of reference for the individual's orientation to his place and role in his family and wider community. They are functions of the interaction of self-image, the image of others and the perception of reality. Values, and the direction and quality of the corresponding social actions, are symptomatic of healthy or unhealty mental functioning. To quote Burgum: "In this sense, it is impossible to define mental health apart from considerations of appropriate action toward common good. Common good may be between parent and child, husband and wife, friend and neighbor, workers on a job, members of a community."*

Assuming such premises are valid, it follows, then, that the goals erected for psychotherapy and the appraisal of evidence of cure would be directly affected by the interaction of the respective value orientations of patient and therapist. To make the issue concrete, would a therapist consider a patient cured if his values remained oriented to a goal of self-realization at the expense of others? Would the patient be cured if his self-esteem remained tied to a form of competitiveness and ruthless aggression which threatened injury or destruction to other persons? To be secure, is it inevitable that

* M. Burgum—"Values and Some Technical Problems of Psychotherapy," presented at the 1955 meeting of the American Orthopsychiatric Association.

one individual sit on another's head, or would it be healthier if they stood shoulder to shoulder on the same bench? When therapists encourage patients in self-assertiveness, it behooves them to consider the interpersonal matrix in which this is expressed. When the "strengthening" of self-assertion is translated into annihilation of another person, the therapist had better take heed. To encourage this is to cripple the patient's self-esteem. To build oneself up by tearing another down brings shame, mortification and a crippling of capacity for effective action. This is no strengthening of the ego. The therapist's goal is not to unharness such destructiveness, but to modify the image of self and others, and related values, so they may learn for the first time the satisfaction of self-expression in consonance with the good of others, rather than in opposition.

When a patient asserts a claim on the therapist for unconditional acceptance and love, this usually reflects a need to deny inner guilt concerning destructive motivation. Here the patient behaves as if he demanded an uncritical tolerance of the bad in himself as well as the good. It is the therapist's task here to win the allegiance of the healthier and more reasoning parts of the patient's mind in the struggle to modify the sick and destructive parts. The patient needs to discover that the therapist may understand and accept him as a human being while rejecting the sick part of him, his destructiveness and the related distortions of value attitudes. Where a manipulative patient treats people as things, it is not in the interest of the cure that the therapist be accepting of this value. At a certain stage of therapy the clash of values between patient and therapist becomes the stage for the working through of residual components of pathology. This need not mean in any sense that the therapist engages in a mission of morally converting the patient to the therapist's value position. It does mean that the patient is required to examine critically the implications of value conflicts within himself, and between himself and the therapist, if he is to get well.

Inevitably, a therapist must concern himself with the problems of joining value and action, action and consequence. His aim should be to heal the split in the patient's perception of reality by rejoining these pathologically dissociated facets of experience.

Present notions of health and illness are in flux. We tend less to view illness exclusively as a distortion contained within one individual. We lean more toward a view of mental illness as a consequence of the internalization within the individual of pathological social processes. We think of mental illness more broadly as being reflected at three phenomenological levels: the distortions within the one individual, the pathology of interpersonal relations, and the unhealthy patterns of social interaction which prevail in the group itself.

Inevitably, this extended view of illness is paralleled by significant changes in the principles of psychotherapy and in the criteria of cure. There is discernible today an increasing need among therapists to consider cure not merely in terms of bringing about the "return of the repressed," or expanding awareness of intra-psychic conflict, but in dissolving distortions of self-identity and corresponding distortions of interpersonal relations. The sharp increase in preoccupation with ego-psychology and group dynamics bears testimony to this. There is increasing concern both with child and adult patients in exploring the emerging relations between the inner concept of self and the concept of personal environment. More and more we see the need for relating disturbances of the mental health of the family group and the surrounding community with emotional disturbance inside the individual. This constitutes a shift of emphasis from an exclusive preoccupation with the internal economy of personality to a broader probing of the relations of individual personality with processes of emotional integration of the individual into the group, and the mental health of the group itself. The growing investigations of problems of interpersonal communication all move in the same direction: that mental health needs to be evaluated on the con-

tinuum of individual, family, social structure and culture. When we view the issues of restoration of mental health in this broader conceptual frame, the role of values becomes less ambiguous. Cure becomes an experience in which the assertion of individual needs, whether for security, self-esteem, power or sexual fulfillment, complements the needs of significant other persons, rather than that one person achieves satisfaction at the cost of another. The achievement of a healthy image of self involves, then, a correct perception of the image of others, their needs, a respect for the dignity, integrity and worth of others, a growing capacity for equality in human relations, as against an orientation to power and exploitive relations between human beings. As we learn more about the relation of values to mental health, we may find a way in psychotherapy to diminish the tensions of interpersonal adaptation, particularly in those spheres where the individual must integrate himself into multiple roles, the requirements of which seem to clash, as for example in the case of the woman who must harmonize the role requirements of wife, mother and career.

Now, let us attempt to relate the goals of therapy with cure and the curative process itself. If we accept the premise that a logical relationship exists between ends and means, then the means of cure—the psychotherapeutic relationship and communication process—must correspond to the goal of therapy. If the goal of therapy is cure in its several meanings, then the therapist must himself be properly cured. It is the ethical obligation of a therapist to do everything conceivable to get cured, stay cured, and continue to grow as a person. To paraphrase Erich Fromm, the only tool a psychotherapist has is himself, and as a surgeon cares for his knife, so must a therapist keep himself clean and sharp. Only as he fulfills this responsibility can he achieve his goal with his patient. The therapist, through his own being, must provide the proof to his patient that mental health is no mirage, that it can be achieved. The patient uses his therapist as a model, a test for his faith in psychotherapy. Does mental health really exist? Do people really love? Is it possible, after all, to reconcile one person's strivings for satisfaction with the needs of others, or is it inevitable that in asserting oneself, one hurts another. When a patient seeks an answer to these questions, he takes a close look at his therapist. The therapist personifies in himself the ideal of mental health as reflected in his behavior as an individual, and as a living representation of healthy patterns of human relations. In this sense, through his attitudes, goals, values, and interpersonal relations, he epitomizes a standard of a healthy social reality. Through the emotional interaction of patient and therapist, it becomes possible to correct the patient's distorted image of self and also his view of social reality.

Another significant criterion for progressive change toward cure, therefore, is the patient's increasing understanding of his relationship with his therapist. Step by step, as the twists of transference are worked through and a more appropriate image of self and therapist emerges, we may feel increasing confidence in the cure.

Mistrust of psychotherapy cannot be dissociated from mistrust of the therapist and mistrust of the self. Mistrust in the patient expresses itself in avoidance of a close relationship, in the defensive preservation of a certain detachment from the therapist. Emotional alienation from the therapist is usually paralleled by the patient's alienation from his own emotions. This tends to express itself in specific patterns of resistance, self-protective behavior which reflects a fear of exposure to hurt and apprehension of exploitation or betrayal by the therapist. In this context, the patient reveals a lack of faith in the possibility of therapeutic change.

The patient enters therapy yet cherishes the secret belief that therapy is some magic hoax that doesn't really change anyone. Here we come flush against a glaring and irrational paradox. The patient sets out to relieve his suffering and change himself, but clings privately to the conviction that the powers of psychotherapy are nil.

The relevance of this for the goal of therapy and criteria of cure is that at a

point nearing termination these deeper suspicions and resistances often become critically intensified. This may at this stage of therapy attain to climactic strength, and unless the therapist is vigilant, such trends may nullify the results of therapy. In this connection, the patient will often harbor the secret plan of mollifying the therapist and escaping from the relationship untouched. He may treasure the fantasy of outwitting the therapist, so that he may stay exactly as he was.

Regardless of critical waves of suspicion and resistance, effective and secure progress toward cure must be mirrored in a tangible forward movement in the patient-therapist relationship, expressed in several ways: diminution of evidences of emotional alienation, increased intimacy, heightening of the quality of emotional communication, increased sincerity and spontaneity, progressive clarification of the image of self and image of the therapist.

Assuming some measure of success in the lessening of anxiety, the resolution of pathogenic conflicts, the removal of symptoms, the melting of regressive defenses and repair of damaged self-esteem, the therapist must keep a close watch for tell-tale signs of growing trust and intimacy, and an increasing sense of equality between patient and therapist. The greater openness, spontaneity and honesty of the patient takes the place of the prior mistrust, fear of exposure and hurt at the hands of the therapist.

As the patient enters this stage, there is progressively less discrepancy between the patient's verbal utterances and his effective behavior. Words are used not to hide but to reveal. Verbal statements, body movement, action patterns and affectivity begin to reflect something approaching a harmonious whole. Whenever there is a significant incongruity between the several levels of behavior, this is invariably an index to the disproportionate pressure of anxiety, and the prevalence of pathological defense behavior. Under such conditions, effective emotional communication is interfered with. As trust in the therapist increases and emotional communication improves, the patient pulls previously dissociated components of his psyche into one piece; he is, in effect, pulling himself together. In a parallel trend, instead of investing himself in the therapeutic relationship in a partial, segmented and compromised way, he commits himself more totally to the relationship. In accordance with this, verbal utterances, body behavior and affective expression merge perceptibly into a unity. At the same time, he is better able to assimilate evidences of unconscious tendencies, particularly as revealed in dreams.

All these trends converge to a point of optimal trust and acceptance of the therapist as a helping person, a friend rather than enemy, a supporter rather than a punitive authority. A full trust of the therapist comes late and with a show of great stubbornness. When genuine trust emerges, the therapist's sincerity and benign purposes have already been tested in innumerable ways. The therapy may then be said to be really beginning and also approaching its end.

In the course of this process, the patient's inner face and the face he presents to the outer world tend to merge and at the same time, he reaches a clearer and more accurate perception of surrounding realities.

These critical shifts in the interpersonal experience of patient and therapist are increasingly reflected in the patient's performance in real life, in work, in personal relations with family, friends and community.

Since by its very nature, psychotherapy is a shared experience, any decision as to the goal of therapy and the proof of cure must take into account the patient's strivings as well as the therapist's standards. Such judgments, as well as the timing of termination of therapy, should not be arbitrary or unilateral decisions on the part of the therapist, but should rather reflect a consensus of patient and therapist as to cure.

The ultimate test is, of course, the objective one: the patient's performance in life itself, the alleviation of his suffering and dread, his confidence and courage in facing life, his capacity to grow, to live fully, to love and share with others the great adventure of the only life he knows.

FREDERICK A. WEISS

Our goal in therapy is determined by our concepts of emotional health and neurosis as well as by our basic view of human nature. Emotional health, as seen from a holistic-dynamic viewpoint, is much more than mere absence of neurotic anxiety and symptoms. The wisdom of our language points the way to a more comprehensive concept. "Health" is derived from "hal," "hale," which means whole. To heal means essentially to help a patient to become a whole, an in-dividual, no longer divided by acquired inner conflict, able to experience and accept his whole self and capable of realizing his inherent capacity for self-fulfillment, love, and work.

In the light of such a holistic concept, *relief of mental or psychosomatic symptoms* appears to be a limited goal. This goal is often achieved by sacrificing more total, vital goals such as the enjoyment of a full life and of intimate emotional and physical involvement with others. Symptom relief is here accomplished by restriction of living. The patient withdraws from interpersonal relationships and thereby avoids situations which might cause anxiety and conflict. This is a neurotic solution which severely limits self-fulfillment. Horney saw it basically as an expression of resignation. Too much of the total goal is here being relinquished.

Another goal in therapy, which reveals itself as too limited and even misleading, is that of "adjustment." Adjustment to what? Adjustment to reality—or, rather, the capacity to face the reality of oneself and of others—is indeed an important aspect of emotional health. But adjustment to the existing environment and its specific values cannot, in my opinion, be considered a valid goal. Conventional values vary too much with time and place to provide a reliable criterion of health. They are heteronomous and interfere with the autonomy of the individual. A goal of adjustment does not foster the development of the self. It often flattens it and paralyzes spontaneity and creativity. Conforming also covers up neurotic fear of disapproval and compulsive drives for approval, glory, or success. It fosters alienation.[1] And with regard to the borderline patient, I agree with Frieda Fromm-Reichmann, who emphasizes that "the recovery of many schizophrenics and schizoid personalities, for example, depends upon the psychotherapists' freedom from convention and prejudice. These patients cannot and should not be asked to accept guidance toward a conventional adjustment. . . ."[2]

There is another, more fundamental, reason for rejecting adjustment as a goal. Mankind was and is always in need of individuals who refuse to adjust to the inhuman values of their environment, not because they are "maladjusted," but because they are basically human. Without such constructive nonconformists, we might never have abolished slavery or Hitlerism, and without them we could not hope for an end to racial and social discrimination which creates such difficult problems in the therapy of members of minority groups. It is characteristic of the healthy individual that he feels free to accept or reject values he finds in his culture.

I said that our goal in therapy depends on our basic view of human nature. If, with Thomas Hobbes, we see "homo homini lupus" as an essential aspect of human nature and neurosis as resulting from an ubiquitous conflict between the innate instincts of libido and aggression and the ego, then the goal can only be the "taming" of these instincts, the neutralizing of aggression by libido, or the erection of even stronger walls against these instincts.

If, however, with Julian Huxley, Kurt Goldstein and others, we see as inherent in man a need for and a drive toward the realization of his given potentialities and of his capacity for cooperation with others, our goal will be different. Clinical experience shows that even in the very sick patient latent energies are available which, freed, will move him in the direction of health. This phenomenon was observed and described by Karen Horney who made it the main thesis of her last book, "Neurosis and Human Growth."[3] Recently, in a discussion

at this American Psychiatric Association meeting, a similar concept also was developed by Franz Alexander, who called "the regenerative faculties of the living organism the basic property of life. . . . The ego's integrative function is the basis of the regenerative process in the field of personality disturbances. . . . The therapist's function consists in helping this natural regenerative faculty."[4]

The neurotic is a victim of early emotional starvation or "malnutrition." For healthy growth the child needs love and full acceptance of his individuality. Without them, he experiences basic anxiety and develops compulsive drives for safety. Lacking genuine acceptance of what he really is, he unconsciously starts to reject that self of his which, as he feels, is not good enough to be wanted and loved. He escapes into fantasy and creates an idealized image of himself which, if he could live up to it, might still gain him acceptance and love. To mold himself according to this image becomes the main unconscious goal of his life. With each step in this direction, he moves further away from his self. Thus his alienation starts early and increases steadily.

The result is the creation of a pseudo-self good enough for survival and for an imitation of living, but incapable of true emotional experiencing and full living. In this structure, the self remains weak and stunted because the energy needed for its healthy growth is used up continuously for the maintenance and improvement of the peripheral neurotic structure which is needed as a defense against anxiety and conflict. *Our goal* is to *free the energy* which is bound in the rigid neurotic system, so that it becomes available *for the delayed growth of the self.*

This is our goal. What about *the goal of the patient?* His goal is divided—as is his whole being at the start of therapy and for a long time thereafter. He wants freedom from anxiety and symptoms, but he experiences his pseudo-self as the only available self and his unconscious neurotic solution as the only possible way of life. The thought of a basic emotional change fills him with increased anxiety and defensive pride. "There is a devil within us," Lawrence Kubie wrote recently. "He is the pride which makes everyone want to be freed from pain without paying the price of learning how to be a different kind of person. . . . Many a patient comes saying, 'Yes, I would like to get rid of my painful symptoms, but I don't want to be different'. . . . This is one of the obstacles to effective psychotherapy. . . ."[5]

In my opinion, the "devil within" is not a mere guardian of the status quo. He is much more active. His strategy, therefore, is highly effective. The patient has made, as Horney expressed it, a kind of "pact with the devil." He unconsciously renounced his true self in exchange for the promise of glory and omnipotence. He usually comes to the therapist just after his attempts at solution have failed, be they his drives for perfect mastery, or for perfect love, or for vicarious living through someone else. He hopes more or less that the therapist himself will become part of his devil's pact. The therapist "should remove all impediments to . . . an undiluted triumph or a never-failing magic will-power or an irresistible attractiveness."[6] The next time, the patient hopes, his solution will work better.

Thus, the goals of the therapist and of the patient are far from identical. In the beginning of therapy both want to move in opposite directions. The patient, driven by neurotic anxiety, wants to improve further and to accelerate his "centrifugal" move away from his weak self, which he rejects and despises, into the unlimited realm of fantasy. The therapist wants to help him to move in the "centripetal" direction to reconnect him with the vital roots in himself and to use the energy which is gradually liberated from the neurotic system for the strengthening of the self.

Decisive for success in therapy is the *change of motivation* in the patient from self-rejection, self-elimination and the drive for perfecting his neurotic solution to genuine self-interest, self-acceptance and self-realization. I consider this change of motivation the *dynamic* goal of therapy. It is approached in the therapeutic process by a steadily growing self-awareness of the patient and his increasing emotional involve-

ment in the constructive battle for his self. Dreams often are pacemakers in this process. In such dreams the symbol of the beginning acceptance of the rejected self may be a human being with weaknesses and limitations, for whose life and growth the dreamer experiences for the first time a new responsibility. From the beginning there are available in the patient, although unknown to him, constructive forces which in the course of therapy will become more and more our powerful ally.

The deeply penetrating and often painful process of emotional change has one indispensable prerequisite. In my opinion this process will not take place except in the fertile climate of a warm, trusting patient-doctor relationship in which the therapist experiences true empathy with the patient and in which the patient feels genuinely accepted. The patient will test the reliability of this acceptance again and again before he risks getting totally involved emotionally. He will need this basic trust especially when he begins to discard the crutches of his neurotic structure, leaves the narrow valley of neurotic security and experiences the first "dizziness of freedom" (Kierkegaard).

Without this basic trust and acceptance even the most appropriate interpretations will be in vain and the therapeutic process will remain a fascinating intellectual exercise. Paul Tillich expressed it like this: "In the psychoanalytic situation the patient participates in the healing power of the helper by whom he is accepted although he feels himself unacceptable. . . . No self-acceptance is possible if one is not accepted in a person-to-person relation. But even if one is personally accepted, it needs a self-transcending courage to accept this acceptance, it needs the courage of confidence."[7]

The therapist accepts the patient *with* his neurotic needs but aware of his potential constructiveness which he will try to mobilize. The patient, however, feels basically unacceptable at this time and often experiences the idea of self-acceptance as an appeal to resignation, an expression of pessimism or even contempt on the part of the therapist. In verbal and nonverbal ways, he unconsciously expresses his feeling: "This self of mine is not worth caring for . . . this is not me." In a deeper sense the patient is right. The pseudo-self with which he enters therapy is not what he really is and even less what he will become. But true change is impossible unless the patient fully accepts and experiences the neurotic elements within him as a part of his present self, be it for example a morbid need for love, or a compulsive need for power. He will never change by denying, condemning, or repressing.

Steadily growing self-awareness is the most important factor in the therapeutic process. But self-awareness is no goal in itself. "Knowing yourself," Kierkegaard says, "cannot be the goal if it is not at the same time the beginning of choosing oneself."[8] The finding of one's true identity, a growing autonomy which moves the patient from dependency—often through a phase of defiant independence—to the capacity for mature interdependence are directional goals in therapy. True friendship and love will become possible only when interpersonal relationships are no longer needed and misused for intrapsychic stabilization. Freedom of choice and moral values will become meaningful to the patient only after neurotic anxiety and the compulsive need to conform have essentially lessened.

A dynamic self-acceptance, with full awareness of the potentiality and of the responsibility for further growth, could be called the basic goal in therapy. The goal in itself is not decisive, however, but the answer to the question: Have we been able to help the patient to find *his* road to self-realization? How far he will go varies; but is he moving?

We do not want to replace the turmoil of the neurotic by a kind of self-complacent stagnation which today often goes under the heading "peace of mind." We hope that the patient terminates his therapy in a state of inner aliveness and spontaneous striving for further self-realization. It is such striving which saves Faust. Searching for omnipotence in his pact with the devil, he almost loses his soul, his true self. But, in the words

of Goethe, "whoever seeks and truly strives, he can be freed from bondage."

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RUDOLF DREIKURS

The function of the psychiatrist differs in many ways from that of any other medical specialist. With the exception of the psychiatrist in mental institutions, he does not see the most serious cases and those most in need of psychiatric help. As a rule, it is not the severity of the condition which prompts therapy, but the patient's decision to do something about it.

Furthermore, in many instances those who come for treatment do so for reasons other than to get well. Psychiatrically speaking, even the term "getting well" is ambiguous and full of complexities since the disappearance of symptoms does not necessarily imply cure.

We cannot assume either that the goal of psychiatric therapy is to satisfy the purpose for which the patient came. Almost every patient believes that he is seeking help, that he wants to get well. This may not be true. The patient may not believe that he ever will get well. Seeking psychiatric treatment is merely a demonstration of his willingness to do everything possible; but while outwardly cooperative, he is bent on proving that even the best doctor cannot help him. Or he may look for sympathy; or may wish to put somebody in his service, to solve his problems and make decisions for him. Some may seek support in their fight against others and hope that the psychiatrist will be their ally. It is obvious that the satisfaction of such demands cannot be the goal of therapy.

Differences of opinion about the nature of the therapeutic process itself confuse the issue even further. The goal of psychotherapy will vary according to the postulations of a particular school of thought. All dynamic schools consider a change in the personality structure as essential. However, no agreement has been reached, as yet, about the nature of the pathological mechanisms and, consequently, of the kind of changes which are necessary to produce mental health and cure. It is the purpose of this paper to present the Adlerian point of view, the dynamic processes interpreted in the light of Alfred Adler's Individual Psychology.

Psychotherapy, as we see it, is a learning process. The object to be studied is the individual. Nobody knows himself. As long as he is functioning adequately, he does not need such knowledge. But if he does not function well, if he becomes deficient or maladjusted, then he cannot change unless he first knows what to change. Everybody knows when he does something wrong, but he does not know why he is doing it. Psychotherapy permits uncovering the motivation of the individual and the nature of his difficulties. It remedies the mistakes made in the natural learning process by which the child developed his personality.

This formulation indicates clearly the nature of maladjustment and emotional disturbances as seen from our point of view. It is a wrong social approach which the individual developed as a child and which eventually led to his difficulties in coping with the problems of life. Emotional and mental sickness is an expression of withdrawal, a declaration of partial or total bankruptcy. Consequently, the goal of psy-

chotherapy is more than emotional adjustment; it is actually social adjustment. This requires the recognition and alteration of the basic assumptions and premises on which the individual functions.

The question then arises, what *kind* of reorientation is attempted which, if accomplished, indicates success of therapy? It is obvious that a temporary change of attitudes cannot be regarded as satisfactory, although it may bring about a disappearance of symptoms and an improvement in the immediate conflict situations. The second question then is whether a *permanent* change of personality is possible. This leads to still a third question: If a change of personality can be achieved, and can remain permanent, do we attempt a *total* change of personality or is a partial change satisfactory?

We can distinguish four phases in psychotherapy: 1. The establishment and maintenance of a proper therapeutic relationship, 2. Analysis in its wider sense, understanding the patient, 3. Interpretation, providing insight, 4. Reorientation and re-education. Only in an interpretative and uncovering therapy do we find all four phases. They are not separated entirely but overlap. At certain points, therapy is more concerned with one or the other.

The establishment and maintenance of a proper relationship is more than a means of therapy. It is a prerequisite for the cooperation necessary in therapy, but in many instances it implies also a therapeutic goal. For many a patient the relationship with the therapist is the first good and close relationship he has experienced. This type of relationship with its give and take, its resilience in conflict and its endurance under the impact of hostility can well form a pattern for future and more satisfactory relationships. This phase, then, implies a retraining for better interactions, almost an action experience. The conflicts between patient and therapist are not considered as an expression of "resistance" but rather as a clash of goals and interests. Through the interpretation of his attitudes and conduct toward the therapist, the patient learns about his own personality, his goals and intentions. The action pattern of their relationship supplements significantly the verbal level of the treatment. The training of a better form of relationship is one of the goals and objectives of psychotherapy.

Phase 2 does not in itself have any bearing on the goal of therapy, except as an indispensable prerequisite to Phase 3. It involves the exploration of the patient's life style, of the basic premises on which he operates, his "basic mistakes" about himself and life, the goals which he has set himself.

Phase 3, providing interpretation, is one of the most important steps toward promoting reorientation. Since Adlerian psychology is characterized by its socio-teleological interpretation of behavior, our exploration of motivation is concerned with goals and not with causes. We try to make the patient aware of the purpose both of his deficiencies and his symptoms. This is the kind of insight which seems to be singularly helpful in promoting reorientation. Introspection as such, recognition of past influences and present "feelings," and concern with heretofore unknown mechanisms do not promote motivations to change as strong as the recognition of self-determined goals and purposes. The neurotic, particularly, is in a conflict between his conscience and his true intentions. The symptoms have the purpose of covering up his real intentions, his private logic. Bringing them to his attention is an important step in motivating him to change them. As Adler pointed out, one of the most effective therapeutic means is "spitting in the patient's soup." He can continue what he is doing, but it "doesn't taste so good."

Naturally, the most important phase of psychotherapy is the process of reorientation. Its extent and intensity alone indicate the success or failure of therapy. This reorientation occurs, at least to some extent, if the goal of the three other phases has been accomplished.

However, certain psychological dynamics take place in this process of reorientation which are not necessarily part of the three other aspects. If reorientation did not have its own dynamic premises, it could not be accomplished without the preceding un-

covering or interpreting procedures. As we know, therapeutic successes *can* be accomplished without them. It is questionable whether they are as permanent and satisfactory, but this is not certain, either. Since the analysis and the insight provided to the patient differs so widely in content and scope among the various psychological schools of thought, each school is understandably inclined to doubt that the other provides real "insight." As an example, psychoanalysts tend to consider Adlerian therapy superficial and merely supportive because it does not explore the unconscious and, therefore, cannot come to the root of problems.

Adlerians, in turn, maintain that no approach provides real insight which neglects the recognition of the life style, the basic premise on which the patient operates. If the insight provided by one form of therapy is questioned in its validity by the practitioners of the others, then one can well understand why certain therapists refute the need for any exploratory phase in therapy. Once they have established a good working relationship with the patient, they immediately move toward reorientation—as in Roger's Client-Centered Therapy, Slavson's Activity Group Therapy, Low's Self-Help Group Therapy, and many others, like hypnosis, waking suggestions and other forms of noninterpretative psychotherapy.

From our point of view, a psychotherapeutic endeavor which neglects an exploration of the social and psychological mechanisms behind the patient's difficulties would be considered inadequate. However, we appreciate other elements of psychotherapy in their psychological effectiveness. Certain generally valid therapeutic endeavors may lead to reorientation without any detailed analysis and interpretation. We use such general procedures, which are often called supportive, if the patient is too confused or too upset to face himself in his motivations, purposes and intentions. Even with patients with a low tolerance for psychological insight we never fail to attempt a communication of their basic goals. A permanent rehabilitation probably requires some change in the basic mistakes in self-evaluation which the patient made during childhood.

The dynamic processes which lead to reorientation indicate both the methods which need to be used to bring it about and the goals to be achieved. The important question with which we are confronted at this point is: can a person change, and—if so—what would motivate him to do so?

Let us state firmly: everybody can change. Man is not driven nor determined, but a self-directed and self-determined being. True enough, he follows fundamental goals which he has set for himself long ago and of which he is not aware. Therefore, his professed willingness to change may be stymied by his inability to know where to start. Consequently, many people try to change by doing exactly what *prevents* a change—they fight with themselves. Similar subjective experiences impress people with the conviction that they cannot change even if they want to. Actually, they are the victims of a fallacious assumption. We can change only if we realize that what we are, and what we are doing, rests upon our own decisions which we usually make without knowing it.

This is the starting point for a therapeutic reorientation. We use a mirror technique to show the patient which of his decisions lead to his actions and movements, including those from which he suffers. This interpretation can motivate the patient to reconsider what he is doing. We use past history only to explain to him his present plans and intentions. He is not bound by the past, although it explains why he feels shackled. His conscience, his desire to conform to social standards, is one of the motivating factors; the other is his growing realization of his own power to make decisions and to change his behavior accordingly.

In some cases such insight may be sufficient to bring about a reorientation; in most instances it is not. Here we need other psychological incentives. They are not specific for the individual and his problems, but are similarly needed and effective in all cases of emotional, mental or social maladjustment.

From our point of view the strict distinction between analytic and supportive ther-

apy is unwarranted. What is called "supportive" is essential in *any* successful therapy. The term "supportive" seems somewhat superficial and misleading. However, reorientation in any form of therapy would be impossible without these elements which constitute a so-called supportive therapy.

Our model of man makes us emphasize certain dynamic approaches. Accordingly, widely known and used mechanisms take on a different meaning. From our point of view, encouragement is one of the most essential factors in all corrective endeavors. It is the basis for any "support" we can give a patient. In the last analysis, strengthening the ego is nothing but encouragement. But, on the other hand, encouragement implies more than is usually assumed when one talks about it. It is by no means "superficial" if it is recognized in its true significance and used properly.

As we see it, every deficiency is based on discouragement. It is so much easier to function well that nobody would be willing to take on all the tortures, sufferings and sacrifices which disfunction entails—unless he had lost his faith in himself, the belief that he can do what he ought to do, and do it well. Only if he is discouraged does he switch to the "useless side" (Adler). This discouragement may occur in a crisis situation, or it may be permanent, dating from early childhood. All mistakes in the life style can be understood through the humiliations and frustrations which an individual experienced in his childhood. Without encouragement, without restoring faith in himself, he cannot see the possibility of doing better. Deliberate and persistent encouragement can stimulate the patient to develop a better—and more accurate—picture of himself. It counteracts his prejudice against himself, which is found in every neurotic; the psychotic, the sociopath, generally cover it up, but they, too, do not believe in the possibility of finding their place in society through useful means.

We are dealing here with an essential point in Adlerian psychology: its emphasis on inferiority feelings as a genetic factor of maladjustment. This emphasis has often been considered as far-fetched and one-sided. How can one single dynamic factor explain all the varieties of deficiencies and maladjustment? To understand its significance, one must realize the social constitution of man. The fundamental desire of every human being is to belong, to have status in the group of which he is a part. He can fulfill himself only within a group. Without belonging, he is lost and meaningless. For this reason, the concern with status is understandable in its pivotal significance. In our democratic society, a feeling of belonging requires a realization of being equal to others. Being less than the others, inferior to them, deprives us of status, and with it, of being part of the group. This fear of being inferior and, thereby, of being deprived of a place is accentuated in our competitive society. The child is impressed with the fact that he counts less if he is inferior to others and that only superiority guarantees him a place in the group. This assumption of being a failure if one does not live up to high standards and cannot maintain superiority over others, at least in certain areas, is often responsible for the declaration of bankruptcy which emotional and social maladjustment implies.

It is obvious that any procedure which conveys to the patient his sense of worth and value promotes a reconsideration of his self-concept. He just is no longer the same person when he loses his prejudice against himself and discovers that he is good enough as he is. The similarity of this process with that in psychoanalytic therapy of helping the patient overcome his guilt feelings is obvious. It seems to be one of the primary goals of every psychotherapy to help the patient to restore faith in himself, to regain his self-respect, to recognize his inner strength instead of seeking constant new proof for his assumed weakness. Rehabilitation implies the discovery of one's own dignity. These goals of therapy are essential in every case and implied in all forms of therapy, from faith healing to psychoanalysis.

Overcoming one's own inferiority feeling has far-reaching consequences on behavior. It removes all defense mechanisms which are understood by us as defenses against the social threat of humiliation and ostra-

cism. The individual, sure of his place in the group, no longer has to defend himself against its social demands. Social interest which is based on a feeling of belonging and leads to full participation can only develop in the absence of inferiority feelings. Social interest and the feeling of inferiority are in converse proportion to each other. The removal of inferiority feelings opens the way for an increase in social interest. Such increase is the indispensable proof of social and emotional improvement. It alone permits the individual to function well in a social setting and to take the ups and downs of life in his stride without becoming frustrated, discouraged, demoralized or sick.

The other by-product of encouragement is the realization of one's own inner freedom. Free from the fears of inadequacy, of loss of status, the individual can utilize all his heretofore-unrecognized inner potentialities. He can devote his energies to whatever is important and useful, instead of being tied down by fears, apprehensions and wasteful defenses. Inner freedom and social interest are not contradictory, but supplementary. Only a free person can truly be a social person, not the victim of social and other pressures, but a free agent as a social being.

This process of learning implied in psychotherapy does not concern itself with personal qualities nor with feelings, assets and deficiencies, but with social values. The influence which we try to exert on the patient contradicts many social influences to which he is exposed. His inferiority "feelings," which are a wrong judgment of self, express the contemporary social contention that everybody who is not superior is necessarily inferior. Psychotherapy tries to instill in the patient a sense of equality to all others, in a society which speaks about equality and grants it to none. Society stimulates vanity and apprehension about status which psychotherapy attempts to eliminate. Society puts a premium on prestige—we try to minimize its significance. We try to remove the patient from his vertical movement by which he constantly measures himself with others. He establishes a fictitious superiority in one moment and an equally unrealistic inferiority in the next. We try to bring him to the horizontal movement which alone can bring fulfillment and self-realization through co-operation, in contrast to the false triumphs over his fellow men in a successful competition. Psychotherapy cannot avoid discussion of the value systems which have formed guiding lines for the patient. It attempts to replace wrong social values with those more beneficial.

This concern with social values, with the "ironclad logic of social living" (Adler) characterizes the Adlerian approach to therapy. It is not surprising, therefore, that the Adlerians were among the first to use group psychotherapy (since 1921). The individual therapist may overlook or deny that he is stimulating new social values in his patients regardless of the type of therapy he practices; the group therapist cannot escape this realization. The group is a value-forming agent. In the therapy group the patient becomes an equal, irrespective of individual assets and deficiencies. This forces him to reconsider his self-concept and his social attitudes and movements.

We are now in a position to answer the questions which we raised before:

1. It is clear what kind of reorientation we consider necessary in a successful therapy. This change implies alteration in personal concepts and in social orientation. Therapy puts the patient on a different track, so to say. He may regress into his old patterns, but the new trend counteracts such tendencies.

2. Can we then speak of a permanent change of personality as the result of a successful therapy? I think we can. The patient certainly is not the same individual before and after therapy. And this change is permanent, regardless of temporary relapses or even reoccurrence of symptoms. We have seen in cases of recidivism that some significant changes had occurred during the previous treatment, but apparently were not sufficient to fortify the patient against new demoralizing influences.

3. This seems to answer the third question, whether we attempt a total change of personality or whether a partial change is

satisfactory. From our point of view, any partial change is actually a total change, since the individual no longer is what he was. However, if total change implies a change of all fundamental concepts and aspects of the personality, then it is obvious that such a kind of change is neither necessary nor possible. The correction of any one mistaken concept is progress. Whether the extent of change is sufficient for future adequate living, only time can tell. In many instances, relatively minor changes in concept and approach proved to be sufficient. The patient, encouraged by his "success" grows, intensifying the changes made in therapy. By and large, whatever changes have been accomplished during therapy are probably less significant than those which occur after termination. The patient finds himself moving in a different direction. The final result of the therapeutic experience is the extent and nature of his new training. Therapy may have been terminated successfully, and still a relapse may occur. Or conversely, a relatively insignificant change in a prematurely terminated therapy may lead to a sufficient and permanent adjustment of the individual.

AIMS OF PSYCHOANALYTIC THERAPY

RALPH SLATER

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SINCE THE beginning of the psychoanalytic movement with Freud, the aims of this therapeutic method have undergone considerable change and development. The first goal was symptom removal. Thus, in the treatment of a phobic patient, the analyst's object was the removal of the phobia. Subsequently, Freud added, as a goal of therapy, helping the patient attain a greater capacity for enjoyment and work. These aims were developed within the framework of the libido theory. Subsequently, H. S. Sullivan emphasized that the object of analytic treatment was to help the patient establish good human relationships. Our aim is to help a patient improve in his relationships with others and with himself. This means helping the patient to move in the direction of greater freedom, inner independence and inner strength—in short, the aim is toward self-realization.

There is a basic antithesis between self-realization and self-idealization. The human individual needs favorable environmental conditions if he is to grow up to be himself, to actualize his potentialities and to make healthy relationships with people. If a child's environment provides genuine love and affection and healthy friction, discipline and guidance, he will grow according to his own inner laws. On the other hand, a disturbed, unhealthy environment makes the child basically anxious rather than basically secure. In these circumstances the child cannot grow in accordance with his nature; instead, he evolves three compulsive moves: toward, against, and away from people.[1] These moves are unconscious strategical devices by which the child attempts to deal with dangerous adults without being too frightened. This inner development means that the child puts a check on spontaneous wishes, feelings, and thoughts. True spontaneity loses its central importance. Real feelings become unimportant and indistinct. It is as though the child said to himself: "It doesn't matter how I really feel and what I really want, as long as I can cope with these people around me without being too frightened." The three compulsive interpersonal moves conflict with each other; the child usually "solves" the conflict by submerging two of the three drives and making one predominant. Why must he go further and develop an idealized image?[2]

The integrating effects of this first solution of conflict are not as great as those of subsequent solutions. The reasons for this loose integration are the immaturity of the growing individual and the fact that this conflict and its solution primarily regulate relations to others. The needs which lead to the creation of the idealized image are:

1. The need for a firmer and more comprehensive integration. The first neurotic step has led to a precarious state of being,

Ralph Slater, M.D., N. Y. U. 1938; diplomate in psychiatry, American Board of Neurology and Psychiatry; Assistant lecturer, American Institute for Psychoanalysis; practicing psychoanalyst.

threatened not only from without by continuance of the original dangerous environment, but also from within, through the impairment of inner strength and unity.

2. The need for a substitute for genuine self-confidence which has had no chance to develop. The use of one predominant approach to people leaves large areas of personality undeveloped, and impairs self-confidence.

3. The need to lift himself above others. This is the outcome of the child's feeling less substantial, less well-equipped than others, particularly his contemporaries.

4. The individual's beginning alienation[3] from himself is the most important factor and gives the other needs their special force. There is a need for a feeling of identity that will give the person a feeling of importance, power and significance.

To fulfill all these needs at one stroke, the person creates in his imagination an unconscious, idealized image of himself. There is a general self-glorification, which is built up from the material of his early experiences and special faculties. He idealizes qualities of his aggression, his detachment, and his compliance. In this process, for example, compulsive selflessness becomes glorious unselfishness. Eventually the person comes to identify himself with his integrated idealized image; he becomes his image. It becomes an idealized self which is more real to him than his real self. This is an inner, unconscious process, made possible for the person by the indistinctness of the real self. Self-idealization is a comprehensive solution, not for one particular conflict, but for all. It has a mysterious, magical quality, promising the person the ultimate fulfillment of himself. Therefore, it becomes essential to him and cannot be abandoned. It is the logical outcome of the early neurotic development, and the beginning of a new development. The energies driving toward self-realization are shifted toward actualizing the idealized self. This leads to a shift in the entire course of the person's life.

The aim of psychoanalytic therapy, then, is to help a person abandon his drive to actualize the idealized self and help him toward self-realization. There are four categories of self-realization:

1. Self-realization with regard to oneself. This means realization of one's feelings, wishes, and beliefs (realization here means "becoming real"). A neurotic person may experience feelings, but they are determined by pride, hurt or fulfilled, or by the fulfillment or frustration of neurotic attempts at conflict solution. Self-realization also means a realization of one's energies, feeling them to be one's own; a capacity to tap one's resources and use one's energies. It also means acquiring a sense of direction from within; having freedom of choice and capacity for decision; the capacity to assume responsibility for oneself; acquiring a feeling of true unity.

2. Self-realization with regard to others. Human relations are an integral and fundamental part of our lives. Self-realization means acquiring the capacity to see and relate to other human beings as they are, and [illegible] to distort them by externalizations and [illegible] them as objects for the fulfillment of neurotic needs.

3. Self-realization with regard to work. This means relating oneself more directly to one's work. The neurotic "I should do a perfect job" becomes "I wish to do a job well." There is a greater capacity to enjoy work for its own sake and not for glory. The result of this change is greater enjoyment of work. Self-realization, in so far as work is concerned, also means that the person makes a more realistic appraisal of the values and difficulties of his work and of his own abilities. Finally, it means that he becomes more productive, and develops his actual talents and special gifts.

4. Self-realization with regard to assuming one's place in the world. This means that the person accepts his place in the world, with its attendant responsibility and is aware of the broader issues.

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UNDERSTANDING THE PATIENT
AS THE BASIS OF ALL TECHNIQUE

EMY A. METZGER

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ANALYSIS is a cooperative enterprise; the analytical situation is a process going on between two persons for the purpose of helping the partner who is sick. Yet though both partners have this common purpose, their ultimate goals differ. The patient's goal is divided: consciously he wants to understand himself, his compulsiveness, his fears; but he is unaware of his inner need to maintain the status quo, to actualize his neurotic fantasies, to live without limitations according to the dictates of his idealized image. He expects magic help and he demands it. The analyst's goal is undivided: he strives for truth, for an understanding of the patient and his difficulties, their development and their present manifestations. He sees the patient as he is today and is interested in this human being's growth and in those factors which have impeded healthy development. His focus is on the road toward self-realization and on those forces which obstruct this road. The analyst brings to this task his interest, his professional training, his experience, his feelings, his wish to understand. Yet he is an outsider from the start.

The patient is involved; he has the raw data, but is interested only in some of them and may even be driven to hide or distort vital parts of them. Living in fantasies, he is often unaware of this distortion of reality. When the analyst tries to understand the patient's difficulties this effort will help to interest the patient again in those aspects of himself which he may have eclipsed, effaced, overevaluated or thwarted.

WHAT IS 'UNDERSTANDING'?

Understanding is a social and specific human process, a moving with one aspect of our being toward the stand which another person maintains, but while so moving still maintaining our own stand. Therefore, we can never be completely where the other person stands—we stand *under* the person's stand; we understand his position, and it is this which enables us to compare his stand with ours. Human relatedness with the partner permits repeated moving back and forth between his and our own position. Each new move may reveal a new aspect of his personality structure and bring into focus deeper and deeper levels. However, such a process of interrelatedness is possible only if we accept and are tolerant of the partner's stand even if it does not coincide with our own. Our feelings of com-

Emy A. Metzger, M.D., is a diplomate in psychiatry of the American Board of Neurology and Psychiatry, a fellow of the American Psychiatric Association and a member of the Association for the Advancement of Psychoanalysis.

passion help us to see more and more of the stand of the other. Understanding is therefore a movement of emotional and intellectual energies. If we lose our own stand altogether, we would not have understanding but blind surrender. If we stand by with a detached, purely intellectual, reflecting evaluation of a person according to conventional "given" standards, we have a "mirror" attitude. It would not be participation but would lead to a mechanical classification of the patient's personality according to an established generalization, as for instance Freud's approach has manifested. However, real understanding is a wholehearted and receptive observing and "feeling into" the other person with all of one's own self. It leads to more and more comprehension of an individual patient with his individual personality and his individual problems.

Understanding at the Start and During Later Periods of Analysis

Knowledge of one's own self, which Socrates already has thought important for healthy living, is a basic prerequisite for the analyst. In his own analysis he has become aware of previously unconscious aspects of his own personality structure. This permits him to spot and recognize trends and drives in the patient of which the anxiety ridden neurotic is unaware. Remembering his own need to allay arising anxiety when, during his own analysis, protective defenses were endangered, he will become aware of the patient's blockages, his efforts to procrastinate, to become elusive, evasive or to ward off premature insights. He will register such strategic maneuvers, understand and keep them in mind though the time may not be ripe and the patient not yet ready to tackle them. Besides, the analyst may not yet have a clear enough understanding of their significance in this specific neurotic structure.

The initial process of spotting single impressions can be compared with the experience of being in a forest. There, one may first see very little: general outlines, shades, colors. After being in the darkness for a while one may recognize here a tree stump, there a branch, some moss on the ground, a wilted flower. At first these impressions may be meaningless and disconnected, but gradually one may differentiate more, see here or there a familiar form, a connecting link. Walking on, a new turn may bring into focus other aspects which may now explain particulars heretofore ununderstandable. Again the view may become obstructed and then may reappear but from a different angle when a new vista is reached. From such beginning awareness of seemingly disconnected factors, the process of analysis moves constantly toward many directions of understanding and comprehending. Rational and irrational forces can become clearer; the intensity of neurotic solutions may be appreciated. All these factors are interwoven, just as they are in a forest.

In analysis one may first become aware of the pervading influence of "pride" in a person's life. Later one recognizes specific prides and then their ramifications, connections, and growth-inhibiting qualities. Or, a general recognition of righteousness may lead to the spotting of militant righteousness in one person, to the recognition of a defensive righteousness in another. Needless to say, this growing understanding occurs also in the recognition of different "shoulds." At such a point we may ask ourselves, "What is this particular person doing to himself?" Or, if one finds *lebensneid*, "What is he begrudging?" Such questions may sharpen our senses toward further searching, recognizing and understanding.

Constantly, new problems arise. With each new problem the process of understanding moves from the general to the particular, then again from the particular to the general. Somebody may have a hostile attitude toward others. Then she may exhibit her self-hatred or, instead, she may be irresistibly driven into a feeling of being abused by others, or, she may be particularly frightened by insights. In another person whom one may have considered friendly and kind, one may suddenly spot callousness; later her need to depreciate others may become overt though it is deeply hidden under a surface attitude of admiration. In still a later hour, we may become aware of her

tendency to begrudge those who, in one specific aspect, seem better off than she. There may be many conflicting manifestations, yet under closer study, they all stem from the same root. Let us take the patient who shuns pride: In another hour his craving for affection may become evident; later, he may reproach himself for certain unimportant matters. These first, apparently disconnected trends will finally fall together into the picture of the self-effacing personality.

In the constant back and forth, from the general to the particular and vice versa, these interrelations become more and more understandable and are recognized as belonging together. At a later point in analysis we may see how one such trend may lead to the next one; the whole sequence of neurotic solutions will become clear, as one factor connects with another one. Previously un-understood factors now appear embedded in this specific patient's personality structure. They are a link in the chain of neurotic development. Understanding the moving toward pride, we see how incompatible, conflicting drives may be the outcome of one and the same drive.

A good example of such contradictory manifestations of one and the same solution is self-effacement with the ultimate goal of dominating others by helplessness. The resulting pervasive, vindictive aspects surprise us at first, especially in a person who consciously believes herself to be saintly and good. When deeply hidden inner conflicts shape up more and more distinctly, we can feel their intricacies and experience their impact. At last the central conflict—health versus neurosis—will come into focus. By then we may have seen how the "inner logic of neurotic necessity" has led to a discarding of reality, to irrationality. We may have approximated the outlines of the "idealized image" which, unsubstantiated by facts, is as irrational as is the resulting pride with its satellites, the tyrannical "shoulds" and "self-hatred."

Understanding a patient will be incomplete if we do not become aware of the intensity of a person's specific neurotic forces and of his anxiety when feeling split open by individual inner conflicts. We then have to feel his neurotic and actual "real" suffering and experience the impact of his compulsive drivenness. Only when we ourselves understand the violence and intensity of all these destructive energies can we evaluate the patient's preparedness for entering the final battle, the struggle between the healthy and neurotic forces. Without such a "living through the intensity of the central conflict," the reality of this struggle cannot be fully experienced, as Rank and Ferenczi first recognized. It is like the difference between "being in jail" and "reading of being in jail."

The Analyst's Feelings: His Tools

It goes without saying that understanding the patient becomes a function of our own relationship to ourselves. If we lay ourselves open without losing ourselves, we can listen wholeheartedly while simultaneously becoming aware of our own reactions to the patient and his problems. When, during an analytical hour we may feel unusually tired or bored we may reexamine the analytical situation and try to understand the meaning of our own reactions in relation to our own specific problems. Still-persisting remnants of our own neurotic solutions may have been stirred up by the patient's associations and by his acting out. Furthermore, we can evaluate the patient's conscious or unconscious technique of irritating us, of trying to distract us from the context, or of making a desperate nonverbal attempt to draw our attention to a specific aspect which previously may have escaped us. Without awareness of either participant, the patient may respond to the analyst's imperfections by vindictively exploiting them. By becoming alert to such strategems we may understand their meanings. Our own inner self is an instrument which often can register such feelings and their meanings more quickly and more precisely than our intellect.

From the start we may have difficulties in understanding because we may over-focus on the content or be bewildered by a sudden turn which seems to confuse or contradict a heretofore logical sequence. But gradually, we can learn how to use our intuition,

which is not a mystical quality but an understanding on a deeper level, and which observes more than we realize. While listening we may be tapping our great store of inner experience. Suddenly something may come up in our mind without our immediate awareness of why it comes up at this particular point. Dr. Horney recalled how a patient spent an hour talking with grief about the death of a relative. While listening, she recalled Ibsen's *Wild Duck* and the quotation, "In a year, her death will be for him a source of beautiful recitals." At this time the correctness of her associations could not be verified, but later they proved to be accurate. This patient had a personality structure similar to Ibsen's sentimental photographer who prostituted his own true feelings for propaganda purposes. He was equally self-destructive and helpless.

Needless to say our understanding does not limit itself to the patient's verbal communications. Every move, beginning with the first letter or phone call, every individual nuance in appearance, posture, clothing, tone of voice, or gesture may be experienced and understood in its significance for the patient's neurotic involvement. Changes in facial expression, moodswings, frequency of breathing, blushing and coughing may reveal important clues and awaken certain feelings, memories and associations. The degree to which we are interested or distracted may become a clue to our reactions to the patient's qualities, his moral fiber, his pain, his anxiety, his efforts to communicate. His attention to our interpretations and his reactions to them will become revealing if we are aware of our inner echo to his affect, or our lack of resonance to the impairment of his emotional energies. We may see superficial issues, complaints or repetitive themes dominating the foreground of his mind while associations more significant, yet vaguely experienced, are kept in the background. His more or less realistic or fantastic attitude toward vital problems may startle us at first, but later we may become understanding of his need to keep distance from them in spite of his urgent request for help. His need to perpetuate the status quo may become meaningful to us when we can understand how much energy he has spent in allaying anxiety, in erecting a facade, in avoiding a fight.

When all our senses have become familiar with his specific way of relating we may get a new understanding of his plight and of his need to keep its deeper meanings out of awareness. The better we ourselves become acquainted with this meaning the more will we be able to appreciate his inner suffering which may be dimmed by his compulsive need to please, to impress, to retaliate. After we become attuned to the patient's individual ways of experiencing and relating, we will no longer think and interpret in technical terms but we will feel how to convey our interpretations tentatively. We will then interest him in the meaning of his associations by using his own language. Besides, we may be able to select whatever will be most important and most feasible to him for an interpretation of the material which he produced. Understanding his dilemma will make us tolerant of one patient's purely impersonal intellectual curiosity or another's need to confuse the issue or a third's attempt to show that he knows everything better. At other times we may tackle his specific ways of blocking his own progress. Such a difficult subject we will choose to bring up when we ourselves are relaxed and when the patient will be more resilient to such a hurt to his pride.

Understanding Changes

Participating with all our faculties in the analytical process, we will become more astute about changes occurring in our patients, and in accounting for them. Knowing that symptomatic changes may have only limited value or may even reinforce pride in magical solutions, we will try to evaluate their significance in the light of our growing understanding of this specific human being's way of experiencing himself. We will not become overoptimistic because of an unexpected improvement, nor will we become exasperated by a sudden relapse into previously relinquished symptoms. We may understand how some—after one or two steps ahead—may suddenly be fright-

ened by a renewed onslaught of self-contempt. We may lay ourselves open to the anxiety which may engulf such a newly stricken traveler on the road toward self-awareness. Being sympathic with his despair, we have compassion for his suddenly arising powerless rage. Feeling ourselves into his situation will prevent a dangerously reassuring attitude. Yet we can communicate to him our active and encouraging "standing by" him, which is crucial, especially when he may turn against us. We may see this as an acting out of his pride which has again turned violently against his constructive forces.

Understanding Dreams

Deeply hidden neurotic solutions may become quite overt in the patient's dream material. What is equally pertinent, we can become aware and alerted by emotions first expressed in dreams and in relating dreams. A dream may not only help us to understand a specific solution by its content or its appearance at a particular time, or its meaning in the present situation but, most important, by its feeling qualities—its emotional intensity in an otherwise cold, detached person. If we feel an emotional resonance in ourselves to the specific feeling quality of the patient's dream it may be startling because the patient may have exhibited a lack of such feelings or have ridiculed them. Yet in dreams he may still be able to experience them in their true intensity. Often such an emotional upsurge in a dream may be the precursor of a release of conscious feeling. Again we can rely on our own deeper understanding of the sequence in which such a return to more spontaneous living may be announced. Feeling ourselves in the patient's situation we may communicate our discovery and its meanings; or something in ourselves may warn us: the patient is not yet ready to take an open stand against his unfeeling pride. If we forego such an inner warning and interpret prematurely, he may stop dreaming or stop relating dreams.

Here, as in all other analytical communications, our intellectual awareness of change will be guided by the intuitive quality of our deeper understanding of the individual patient's capacity to take in that which may still be too upsetting to his shaky equilibrium. In singular instances, however, our own spontaneous reaction to such an emotional reawakening may be transmitted to the patient, verbally or nonverbally, explicitly or implicitly. Our understanding of his reaction to our understanding interest may set something going. This may become overt immediately, in the following hour, in a subsequent dream, or at a much later date. To register and evaluate such an experience with all our being may fortify the analytical relationship.

Understanding the Analytical Relationship

If we are wholeheartedly interested, the patient may intuitively become aware of our respect for him, our sincere wish to understand him, our own stand in its various aspects. This mutuality may then give him the courage to move closer to his own constructive forces, because he now feels more secure in the common understanding of previously eclipsed or distorted aspects of himself. For the time being, he may accept himself as he is and try to understand how he became what he is. He may even become more active in examining his inner reality. But such a frank acceptance of his own imperfection may again arouse anxiety. Neurotic defenses may interfere with his wish to become emotionally alive. He may again withdraw from this stand for a constructive reorientation because anxiety may become paramount.

Understanding the individual patient's degree of alienation—the amount of his detachment and externalizing, the still-persisting adherence to narcissistic goals, the relative strength or weakness of his aliveness, the obstacles against his emerging spontaneity—will become a new task for the analyst. What we must evaluate then is the intensity of anxiety in comparison to the patient's capacity to endure its torture. Such a difficult weighing is possible only if the analyst's own feelings are wholeheartedly involved in this understanding. Here, a detached analyst will be at a loss,

whereas a comprehending one, a warm human being, will stand by with all his faculties and give just as much help as a panicky patient can take. Overdoing this would lead to a renewal of dependency dynamics or to the more dangerous complete withdrawal. But with a wholehearted understanding of the analytical relationship and its intricacies, this period can become a living experience; the analyst's acceptance gives the patient the strength to move again and again toward new efforts to take a stand for himself as he is, and against those forces which obstruct his healthy development. Gradually his claims will become less and finally they can drop out. Then he will be less egocentric and more self-aware.

As his self-contempt diminishes he gains respect for himself, for the struggling human being in him. Such a freeing of oneself from the imprisonment of neurotic involvement can liberate previously eclipsed emotions. At first he may experience them only as a fleeting, abortive feeling or as physical well-being, warmth. But with the analyst's steady encouragement to live with this feeling, he may deepen such an experience. However, we will have to understand patiently his still-persisting need to condemn such feelings or his pride in embellishing them. It is self-evident that our own emotional participation will prevent a judgmental attitude. Furthermore, it will help the patient to steer free from rationalizing. Even if he is still inclined to intellectualize his present stand, we must try to understand this as the position of a man who has to find his way toward freedom after having been in prison too long. "Don't go overboard on feelings," Horney warned at this point of her lecture.

Much work must be done until the patient has overcome the experience of emptiness which usually arises in a person who gives up neurotic solutions dictated by pride, and self-contempt, and who has only incompletely reoriented himself as to his assets. The sensitive and understanding analyst will try unflaggingly to awaken the patient's numbed confidence in his own creative abilities until such a time when the troubled human being is strong enough to mobilize them for self-realization.

A PHILOSOPHY OF GROUP PSYCHOANALYSIS

SIDNEY ROSE

THE PSYCHOANALYST who begins group therapy has to rely on theoretical concepts he found useful in his work in individual therapy. These are soon found wanting and he is led into a search for more comprehensive concepts which can to some extent be found in the other social sciences. The broader perspective permits a more thorough understanding of the relationships of individual to society, and a greater appreciation of the complex interrelatedness of all human activities.

This paper presents some reflections about the relationships of individuals in society and their connection with group therapy that have come from work in group psychoanalysis and the reading that it has stimulated. What has been most significant is the realization that the concepts of conflict and patterns of integration that are of such great value in individual analysis are also useful in group analysis and are universally applicable. The difficulty of the task consists in identifying and describing the nature of the forces that make up relationships and conflict solutions. In the physical world, measurable abstractions, permitting the expression of conflicting forces in mathematical equations and laws, can be made. Here we deal with interacting constants.

In dealing with living situations we must contend with interacting variables and the task of selecting what is most relevant among the conflicting forces is of paramount importance. Thus, when dealing with the biological world a different order of abstractions becomes necessary. Quantifiable abstractions and their expression in interacting constants are possible to a limited degree only. Functional entities on an empirical basis are used and their usefulness can be extended if each entity is looked at in terms of conflict, conflict solutions and integrating patterns. For example, each organism is the more or less successful solution of conflicts between its needs and the environment. The latter consists of unsystematized and loosely systematized, heterogeneous elements as contrasted with the organism, an autonomous, systematized entity that has learned to deal with the environment.[1] Each organism has achieved a degree of adjustment and integration into the environment upon which it is dependent, and this has enabled it to survive and reproduce itself. These patterns of integrating, these successful solutions of conflict with the physical environment, become structuralized and an innate part of the organism.

In addition to the physical environment, organisms have other life forms to deal with. Struggle and conflict occur and this leads to patterns of cooperation, competition, or avoidance, or any combination of these three. These are patterns of integrating, solutions of past conflict which become organically imbedded and are handed down to new generations.

Sidney Rose, M.D., lecturer, American Institute for Psychoanalysis, New School for Social Research; member, Association for the Advancement of Psychoanalysis; diplomate, American Board of Neurology and Psychiatry.

Man has similar patterns of integrating present at birth, but he also has an unique cultural and social heritage. Part of this heritage is the altered physical environment to which he has grown accustomed. Man is different in his capacity for mastery over the environment, which permits him to alter it to some extent instead of changing himself biologically to fit the environment. The advantage of this, so far as retaining flexibility and permitting rapid accommodation, is obvious. However, this modified environment becomes a permanent part of his heritage and he can no longer live without it. It becomes a part of him, similar to any organic evolutionary development, without the same degree of rigidity. These are solutions of conflict arising out of the struggle with the physical environment. The tools, buildings, means of production, etc., represent concrete solutions of past conflict by means of which he has achieved past mastery over the environment and which he will continue to use for the same purpose.*

Man's environment consists of other men with whom he deals, further complicating the relationship with the non-human world. With the latter it is more a question of mastery over influences which could harm him, or control of forces for his own benefit. In relating to man himself, different patterns evolved. These could be studied in terms of three general directions: cooperation, competition, and avoidance. These correspond to Horney's three moves: "Toward," "Against" and "Away From."[2] It is in the original family setting that individuals first learn the different patterns of integrating which are later needed in order to fit into the larger whole society.

* In this paper resolution of conflict means the successful ending of conflict. Solution of conflict means the structuralized tool or technique used for meeting conflicting situations. Healthy solutions of conflict are patterns which harmonize conflicting interests to the mutual advantage of all, with retention of plasticity to meet new conditions. Neurotic solutions of conflict, while perhaps producing a pseudo-harmony and unity for a time, contain within themselves seeds of their own destruction because of a too-great sacrifice of plasticity.

The family teaches how essential cooperation is. Ashley Montagu points out how the capacity to cooperate is innate biologically in all life.[3] When it is lacking in humans it is evidence of disorder and disintegration and is contrary to human survival and growth. This ability of men to join with each other enables them to form *identifiable* groups. They can join together and turn their combined powers toward the mastery of the physical world or for mutual protection against enemies. They can join with each other and mutually satisfy all kinds of needs. This ability of men to form groups has led to the hypothesis that society is like an organism. This supposition has fallen into disrepute, but if used judiciously can still be of much value. As Angyal puts it, human beings are attempting to integrate into a supra-individual unit.[4] These supra-individual groups that men tend to form lack the unity and wholeness of an organism. It is important to remember that each human has no existence without society, and in attempting to satisfy his own individual needs he is also meeting the requirements of the social whole. Society attempts to establish a social whole using certain integrating patterns. Various cultures differ in that they form different integrating patterns for the solutions of universal human conflicts that arise when certain organic human patterns become opposed to the existence of society. Sex patterns are examples of the opposition of organic human needs with the need to preserve society. Sexual maturity occurs long before individuals are psychologically or economically mature enough to form permanent relationships in marriage, with children. All kinds of sex taboos and conventions have arisen to control this powerful conflict. Even the incest taboo can be looked at as a solution of conflict between the needs of society and the individual's sexual cravings. It is probably the disruptive effects of sexual permissiveness in the family and its threat to society that has led to the incest taboo, rather than any innate instinctive tendencies to incest.

Each individual, in order to maintain his wholeness, to survive, finds it necessary to

satisfy his needs within the social context. He has to integrate, fit in with the social whole. The social whole is a fictitious concept but is useful when it is kept in mind that there is a striving to form such a whole. Actually, there are attempts to integrate into smaller units which in turn tend to integrate with each other. No doubt, at first, there was conflict as each individual and group competed with each other, but in time it was found advantageous and preferable to cooperate with one another. Patterns of avoiding destructive conflict and increasing cooperation were slowly established.

The theme of conflict and cooperation assumes a new dimension because man's ability to think, to symbolize, to remember, gave rise to a great variety of ways of cooperating and avoiding destructive conflict by using old, remembered ways of having solved similar conflicts in the past. These ways were then handed down as language, convention, institutions, traditions, laws, etc. Whenever destructive conflict arose, men had to find ways of cooperating (not always successful) which were then crystallized into customs and conventions. These are the solutions of past conflict forming the social systems which vary from culture to culture and are then handed down from generation to generation. These free man to direct his energies in ever-new directions by resorting to old, institutionalized techniques for resolving conflicts of interest.

The social systems are the complex ways of integrating in the direction of harmony and cooperation and reducing destructive conflicts. A simple illustration of this is the following: In some bakeries large crowds attempted to shop at the same time. Each person had to watch for his turn. There was tension and great potentiality for destructive conflict. Occasionally, the latent conflict would erupt as some aggressive individual attempted to get served ahead of his turn. A system was devised to meet this and each one on entering the store took a ticket with a number which determined his turn.

Out of the original destructive conflict there arose a new solution effective for meeting the situation, and if this system broke down a new one could be devised. The same could be said of conventions, traffic lights, contracts, etc. They all symbolize the harmonizing of conflicting needs, so that destructive conflict is minimized or avoided and the potentialities for cooperating and relating to each other are increased. All patterns of behavior are efforts to relate to the present situation by using tools and techniques and patterns of conflict solution which were learned in the past or, if they are not successful, by devising new ways. In man these solutions exist to a large extent at a symbolic level and it is this capacity that has enabled him to develop his complex social systems.

If we look at man's social system and compare it with non-human systems we see important differences. In the non-human the particular system that will develop is relatively fixed at birth; it is innate. With man the capacity exists but the particular kind of social system that develops will depend upon environmental pressures which come from traditional and conventional codes of behavior. Man has the capacity to reexamine the social systems, reevaluate and change them. The non-human social systems are relatively rigid; there is strict conformity and subordination of each member to group needs. Once the individual's role is established it remains that way through life, even to the point of anatomical differentiation. The individual gives up his individuality and independence for the sake of group integration and autonomy.

In man's social system there are many subdivisions which come about through his capacity to think and symbolize. Man has the ability to identify the system into which he is integrating, perform the varied functions and assume different identities as he shifts from one position to another, higher or lower. This stems from his capacity to see himself in the role of another, to play that role in imagination and finally act it out in reality.

This comparison of human with non-human groupings gives us a feeling for direction in terms of what is more human in healthy group integration. Already, in the above, we can recognize distinctions

between authoritarian and democratic systems. In the latter the direction is toward maintaining individual autonomy, freedom of movement in the group, freedom to move from group to group, the chance to develop depending on the individual's wishes and the needs of the group, and the capacity to reexamine and reevaluate old conventions and laws in terms of new conditions. There is the capacity to form new groupings and to meet changes with new solutions.

This brings us to the problem of group-integration, where the autonomous individual has to satisfy his personal needs and integrate them into the social whole. Integrating means working toward forming a more effective unit in the harmonizing of differentiated and specialized sub-units. The degree of identity as a unit varies considerably when comparing an individual and a group. The individual is nearer to being a closed system, who is still to some degree open and forms part of a larger system. It fits into the physical world directly but fits into the social whole by means of various kinds of group systems. The individual is a tight system—the boundaries (areas of interaction) are more easily discernible and there is an indispensable interdependence of parts. Groups are comparatively loose systems, less identifiable as distinct entities, with vague varying boundaries and only temporary, less-essential interdependence of parts.

Integration in an organism means that the organism is a unit and functions as such. There is a governing principle which in the organism guides the many sub-systems and coordinates them in the interest of the organism as a whole. Whatever affects any part of the organism will be dealt with by the organism as a whole.[5] There is immediate communication, balancing and counterbalancing of many different systems, each one with a governing principle of its own. There is a division of labor and when any part is unable to perform its function, then the whole organism reacts to the lack and the task of making up for the lack is taken over by other systems or combination of systems.

Two principles stand out: The organism functions as a whole for whatever its needs are; there is rapid immediate communication of these needs throughout.

In any human group there is a tendency to integrate into a superindividual unit, but this has to be limited by the nature of humans: 1) Human beings are separate autonomous systems and the interests of the group do not supersede those of the individuals; 2) Communication is limited and faulty, and again this limits the formation of group units; 3) The needs of each human are so complex and varied that no single grouping can fulfill all these needs requiring his participation in other groups and social situations. The more integrated it is the more a group has its own unique identifiable characteristics and is influenced by changes in any member.

In any human group that does form there will be the tendency to integrate, and such integration will depend on the group aims, organizations and the communication network. Each group has its governing principles and integrates with other groups in terms of the social whole.

Each group can function to further the self-realization of each individual or to satisfy neurotic needs. In meeting these needs we can examine the group purpose, that is, the goals and aims of the group, the idealized image of the group, and the group means—how it achieves its purpose. In the latter, we consider the group organization and also the make-up of each individual. At each one of these levels we must ask whether it is in keeping with the healthy or neurotic needs of the individual. The aims of the group may be toward self-realization but the organization and methods may not. Where the ideology, the organization and the methods are all in keeping with the self-realization of each individual, then we can consider such a group as ideally rational.

The organization, methods, ideals are all part of the social heritage which influence each individual's self concept. When there is an optimum degree of flexibility, the self concept that develops is not marred by conflicting feelings as to one's worth. There is the capacity to experience oneself as a

member of the human race, to accept human limitations, with a great capacity to join other, different humans and to cooperate with them, depending on what interests each one wishes to develop. When anxiety is present there is always the need to idealize the self concept and identify compulsively with certain narrow limited groups, which actually exist or exist only in the imagination, and attribute to them supposedly superior values.

It is not my intention to elaborate on what is healthy or neurotic on these different levels but to point out certain qualities that go along with different integrating patterns on all levels, whether they deal intraphysically or interpersonally, intragroup or intergroup.

There are two opposing patterns of integration. One goes in a democratic direction and the other in an authoritarian direction. Each solution of conflict, which is of course an integrating force, can function to further the self-realization of each individual or to satisfy neurotic needs, and can vary from great rigidity to great flexibility on all levels. The seriousness and intensity of the original conflict determines the rigidity of the solution and mars the later capacity to change it to meet new conditions. This is not unlike the individual neurotic solutions of conflict that are precipitated in the individual as a result of devastating conflict in the early years. As an analogy we can contrast the solutions of conflict that have been worked out between this country and Canada with those that exist between Germany and France, because in the latter the destructive conflict was so severe the solutions carried with them old terrors. The treaties (solutions of conflicts that had to be devised after the defeat of Germany) had to be enforced by an army of occupation. Having been engaged in a death struggle with each other meant that future contacts would cause reactions to each other not unlike an allergic reaction. Any issue that comes up is not dealt with realistically and locally, but becomes a matter for the entire country. Everyone feels threatened and energies are directed from other activities and pursuits to this minor issue. Here again it is like the neurotic individual who reacts to a life situation with anxiety. Parts of the organism are called up as part of the defense (psychosomatic patterns) which have little to do with the nature of the real threat.

By contrast, the dispute that may come up between Canada and the United States is more likely to be dealt with locally by the properly designated agents and does not become a cause for hurt national pride because of past destructive conflict. Psychologically, it can be compared to the idealized image and pride system that Horney describes for the neurotic character structure of individuals. There are the eternal fears and suspicions, the feelings of superiority and pride. There are the tendencies to feel quickly humiliated and react with hurt pride. There are the difficulties in cooperating and above all the self-destructiveness implied in such a deprivation. This can be contrasted with the dealings of this country with Canada, where any conflict of interest is dealt with realistically, with limited carryovers from past destructive conflict whose allergic potentialities for awakening defensive fears have little to do with the present conflict. There is little neurotic pride, little need to save face.

In all this it must be appreciated that certain patterns of integration seem inflexible. Such seeming inflexibility, however, is really stability which is established over a long period of time by success in meeting conflict. It is the stability of steady states, homeostatic dynamisms and healthy conservatism. By contrast there is the rigid inflexibility associated with irrational authoritarianism, which so exaggeratedly feels threatened on unrealistic bases. Different social systems have the capacity to encourage one or the other, i.e., to encourage a feeling of belonging to the human race or compulsive group identification with feelings of superiority; one pattern tends to be flexible, liberal and judicious, and the other leads to rigid authoritarian dogmatic ways.

An important integrating force is the need to satisfy the basic feeling of belonging, that one has a place in the world. The healthy we-ness is the perception of self as

a human being and secondarily in certain roles or as members of certain groups. In effect, it is as if an individual says, "I am a human being who is an American, Jew, Democrat" and so forth. The feeling with this is primarily how much like other human beings one is, with proportionate emphasis on the differences. In man's present stage of development the capacity for identification of self as a human being is limited to a comparatively few people.

The great presence of anxiety in our culture, particularly in America, arises from the fact that group identification is confused and splintered, and an individual is confronted by conflicting loyalties in his effort to identify with any one group. Even the neurotic tactic of externalizing to members of other groups is thus made more difficult. There is also confusion so far as his status is concerned, for he may be at the top of the scale in one group, but at the bottom in another. The class-conscious Englishman usually feels the same degree of superiority no matter where he is; at his work, on the golf course.

There is one principle of living which permits a flexible approach to this whole question of group membership, and allows mutiple group membership without the excessive attending anxiety. It is the democratic principle that an individual is first a human being, not superior or inferior to others. There may be superiority as to strength, attractiveness, and so forth, but this never confers the right to feel superior to others as a human being.

For the individual this democratic spirit implies a privilege and obligation to develop himself and his capacities fully. While he delegates functions, responsibility must still rest on his shoulders. This is the old truth that each one has responsibility for his brother. The integrating influence which comes from the need to belong can go in a neurotic direction as part of an authoritarian system. In it there is a continued need for compulsive identification as a member of a certain race, religion or nation. This can serve to relieve the basic anxiety by alleviating the feeling of isolation and weakness and make the world seem less hostile because of group protection.

Such integration into an authoritarian group always has running through it a powerful undercurrent of anxiety which is brought to the foreground when the group is threatened. Power-seeking leaders always work to maintain a tightly knit group by cultivating imagined threats and promising safety and security if it submits to their leadership. This is not only the pattern followed by a Hitler, but also by some religious leaders who threaten people with Hell and at same time appropriate unto themselves powers of forgiveness and protection in the hereafter.

Interpersonally the group can solve the basic conflict. The individual can identify his status in the group and there are those to whom he can submit, and those whom he can dominate. The examples of this are the various caste systems. The self-effacing person needs groupness because it promises him protection and satisfies his dependency needs. He can belong and feel loved. The expansive person can use the group to climb, to exploit others. Even the resigned persons finds people in the group to be away from, and in a detached way experiences his conflicts outside himself as the observer.

Group identification can relieve the individual from the tension of internal conflicts. He can imagine himself closer to his idealized image by his mere membership. The group ideals are his already fulfilled. Accomplishments by other members of the group or by the group are reasons for inflated pride. As he loses his identity in the group identity he gets the oceanic feeling he is the group. His pride in group membership enables him to externalize his self hate on non-group members. He belongs to the "superior race" or "chosen people," and others are inferior and rejected.

One can also consider the direction in which the group's ideals go and how these particular kinds of ideals may satisfy each individual's prides. In a religious or philanthropic group there can be the satisfaction of the saintly, loving side of the idealized image. In political, army, or occupational

groups there can be the satisfaction of the idealization of mastery.

In a healthy system there is a need for leadership[6] which ideally falls to those most capable of fulfilling this function. Leadership is not to be considered as conferring superiority on any human being. In our democratic system an individual may hold an important position in one group and a comparatively unimportant position in another group, and he is regarded in terms of his function in that particular group. In the authoritarian group the leader assumes responsibility for the individual and dictates to the members their particular roles. Such leaders can cloak themselves in different kinds of omnipotence. All knowledge, authority, decisions come from above. The members have to accept a submissive role. The authoritarian regimes are dangerous in that they can be effective in alleviating anxiety, and reenforce and support all kinds of neurotic solutions.

There are many who need the security, the lack of responsibility, the submissiveness of living in and conforming to such a regime. It is conceivable that man's evolution can go in a direction which ultimately will lead to a cessation of man's individual growth and development. Because there is such a danger, our responsibility is all the greater, since we do have some knowledge of what is going on.

In looking at the family as a group it can be considered as rational from the point of view of its purpose, which is the growth and fulfillment of each member of the family. This means the development of a self-concept and behavior patterns which permit integration into the social system. This rationality arises from the obvious fact that young human beings need aid and assistance in the process of growing up. In keeping with the nature of man, conventional and cultural patterns will to some extent determine the organization of the family and this may or may not be in keeping with the optimum fulfillment of each individual. Ideally, to the degree to which each is free from inner neurotic conflicts, to that degree will each be free, within cultural and conventional limits, to operate according to the best interests of each member. Democratic principles will be followed where each is respected and required to accept responsibility according to his ability and stage of development. Although parents are in a stronger, even authoritative position, it does not alter the basic sense of equality. Where parents fail to give children responsibility in keeping with their age and development—either too much or too little —it means that they are operating irrationally and the family group may fail to fulfill its rational function.

The functions that the family fulfills for each member is ever-changing, in keeping with the different individual requirements of each age. It retains its cohesiveness and group character as long as it satisfies the diverse needs of each as they complement each other. Complementing needs are, for example, the different parental sex roles, the parent-child symbiosis, the parental sharing of responsibility.

An important function of the family is the preparation of the dependent child for his participation in the larger social system and also for his separation from the family unit to set up a new family of his own. The family provides the atmosphere and the climate which, over a period of years, affects the individual's character structure. It establishes the individual's system of codification and symbolization which permits him to function.

By understanding the meaning of the atmosphere and how the child is influenced we can speculate about the atmosphere that is necessary in group analysis in order to alter in a rational direction the individual's symbolic system.

So far, groups in general have been discussed and the comparison and contrast with the analytical therapy group can be rewarding.

1. The need to belong is an integrating force in each group which strives to maintain the group. Satisfactory integrating is accompanied by a feeling of belonging and its influence springs from its ability to relieve basic anxiety—that is, a feeling of isolation and weakness and that the world is hostile. When the basic anxiety is great

the individual is driven to find integration patterns which give him feelings of fitting into the world as he sees it. Common group identifications, such as those based on race, religion, class, wealth, are commonly misused for this purpose. Because groups in therapy are made up of individuals with varied backgrounds it is more difficult for each member to rely on the usual false distinctions of race or religion for this feeling of belonging.

In group therapy in its early stages the feeling of belonging can come from a neurotic source based on feelings of mutual commiseration. This is true for those who put feelings of weakness and suffering in the foreground, while those who have pride in strength and contempt for weakness have an aversion for group therapy.

In group analysis the ultimate purpose is to satisfy this need to belong by appealing to the common constructive core of each individual. Each individual can symbolize a segment of humanity and since the group is made up of individuals with varied backgrounds it is more possible for relatedness and groupness to be based on what is universally human.

2. Purpose of the group: Most other groups, with the exception of the family group, usually integrate about a certain function which only incidentally might have something to do with personality growth. The prime purpose of the analytical therapy group is to undermine unreal concepts of the self and the world and replace them with more appropriate concepts.

3. To fulfill their function, other groups have rules, conventions, customs, prescribed procedures, laws, all of which are for the purpose of facilitating integration. In the analytical therapy group these are kept at minimum, so that new patterns of integrating with each other have to be worked out.

4. In society there are the great number of systems and sub-systems and the individual is called upon to function in many of them. In each one he may play a different role. The more structure each system has, the easier it is to identify the role and the easier it is for the individual to fill. In these tight-structured systems very definite functions are called for and less is left for the individual to choose or decide. In the therapy group there is no definite function or role and the individual is confronted with choices all the time. He cannot resort to group-structured functions to tell him what to do. Because of this lack of role, the manner of relatedness of each member to the others in the group process is different from any other. It is not a relatedness of all members to the one leader, but a constantly changing process of involvements with each other in various combinations as different feelings come to the foreground.

5. Because the individual is in such an unstructured situation he has to resort to his own very personal value system to guide him. Here it is that his neurotic defenses come to the foreground and give rise to all kinds of friction and alliances, all of which tend to threaten the integrity of the group. In all other groups these differences have to be worked through in order that the group carry out its function. In the analytical therapy group, frictions and the unholy alliance themselves are the material for group work.

6. In other groups there is an hierarchy, there is an increase of responsibility from below up. Possibilities for choice and for decision increase the need for ever-greater awareness in the individual, the higher he goes in the hierarchical scale. To put it differently, the higher one goes the greater is the need for governorship (usually called leadership). In the analytical therapy group, while initially the psychoanalyst plays the leading role, the capacity for choice is latent in each one and its development is encouraged. A degree of prestige goes along with such demonstration of governorship but this prestige is not equated with superiority as a human being.

7. As compared to all other groups communication is on a deeper feeling level. Because it is on this level where communication of feelings is so difficult greater resort is made to symbolic forms and metaphorical expressions. It means the expression of likes and dislikes, of fears and hatreds, to each other and the constantly changing currents of these rational and irrational feelings.

Rather than a rational, logical, concrete thread, it is the emerging emotional atmosphere which is the area of conflict from which develop new conflict solutions and ways of integrating. Communication in the group permits all kinds of complex interrelatedness with each other. The communications paths are kept open and when certain communication patterns develop they become the subject for analysis and help point the way for self-understanding. The tendency of some to respond only to certain individuals or only in response to certain emotional currents point the way for further analysis.

8. Other groups have their character determined by the nature of the function, the ideals of the group and the customary ways of integrating. It is also true that the analytical therapy group will have its unique characteristics depending on its governorship and its ideals; but the nature of the analytical working culture means that each group will have its own uniqueness determined by the great individuality encouraged in each member. Just as each patient differs, so does each analytical therapy group. As times goes on the group develops a background, a history of having been through tough spots before, which permits the establishment of a reservoir of successful resolution of past conflicts. For each group this is different and unique.

9. Unlike other groups (except the family and possibly educational groups), there is growth and change in the therapy group. There is a certain expectancy that there will be repetitions of behavior patterns and feelings. The emotional currents of the present flow into the background and furnish the anticipations for the future. The successful breaking down of past patterns awakens anxiety which in other groups would be disruptive but in the analytical therapy the activiation of such anxiety is a necessary accompaniment of the therapeutic process.

Conclusion

The attempt has been made to put the concept of conflict and conflict solutions into the foreground of study. This concept is universally applicable. For living beings the original conflicts give rise to conflict solutions which in time become fixed as integrating patterns. Biologically they become part of all steady states and homeostatic systems. Psychologically, conflict solutions which become integrating patterns must be considered on the symbolic level. The symbolic forms on the social level are laws, conventions, institutions, traditions, contracts, treaties, and so on. These are the guides for attempting to integrate into a group unit. Because of the nature of humans and their diverse needs, this group "entity" must be primitive and loosely integrated. Whether for the individual or the group, no matter what the needs are to be satisfied, there are two diverse integrating directions. One is toward flexibility, tentativeness, liberalism. Where survival is seriously threatened the integrating patterns become less flexible which is a necessary development. Where the threat to survival is exaggerated the integrating patterns become unnecessarily rigid and interfere with further individual or group development.

Individuals who have developed such rigid ways have narrowed their perceptive horizons because of anxiety, have diminished awareness of possible new ways of solving conflict, and have lost the capacity for change. The same may be said for groups that have such rigid integrating patterns.

The analytical therapy group is a small society with its own culture favoring and valuing some behavior patterns and rejecting and disowning others. While it is functioning there is the attempt to maintain a group unity—a co-operative atmosphere.

Smooth co-operative functioning in the group situation does not occur because there is also the requirement that each involve himself in the group process. This means that his rigid integrating patterns will inevitably come into destructive conflict with rigid patterns in other group members. There is then the chance to experience internal conflict since these destructive patterns threaten his membership in the group and the integrity of the group. The neurotic patterns are identifi-

able by certain qualities having to do with rigid prides, feelings of self-contempt and compulsive group identifications with feelings of superiority. These can be contrasted with feelings of group unity based on universal human experiences and a common fate. Out of the working through of destructive integrating patterns come intrapsychic changes which can be expressed in changes from an idealized self-concept to a more real and human one recognizing human limitations. What is true for an individual is also true for a group and for society.

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THE CONCEPT OF UNCONSCIOUS ANXIETY AND ITS USE IN PSYCHOTHERAPY

JOHN R. REID

THE CONCEPT of unconscious anxiety may be nebulous, but evidently it is also useful. For it has survived decades of logical criticism and, like the dialectic of Hegel and Marx, seems to thrive on the contradictions that apparently lurk within its obscure depths. Such an intellectual phenomenon is, of course, no novelty. Indeed, it perhaps attests, as some would allege, to the vitality of the concept, with its inner tensions and conflicting references, so full of dynamic significance that it cannot be compressed, without misleading omissions or falsifying distortions, into any self-consistent definition. This may be true, but before we feel too virtuous about our intellectual limitations in the face of nature's infinite variety, let us remember that mystical absorption in a subject is not scientific knowledge about it, and that language, if it is to be usefully informative, must not imitate the obscurity of what it purports to describe. In these verbally luxuriant times, any psychiatric theorist who seriously desires operationally meaningful formulations needs a scalpel more than he needs a sponge. But more than either of these, since it is a necessary condition of intelligently using both, he needs a clear and unequivocal light on the subject. The purpose of this paper is to try to generate some of this "Natural Light."

Since the meaning of "unconscious anxiety" is arrived at, in part, by negating a part of the meaning of "conscious anxiety," let us begin by examining the meaning of this latter term. As generally used, outside of Freudian circles, the qualification "conscious" is redundant, for the term "anxiety" refers, by well-established usage, to a felt state of mind that is consciously suffered. If this usage is followed, and the definitional rule implied is adopted as our standard, then it obviously becomes inconsistent—it is logically impossible—for us to speak of unconscious anxiety. For on such definitional assumptions this locution would, like "unround circle," fall into the null class and be the name of nothing. Patently, to avoid this logical consequence we must change our definition of "anxiety," so as to permit it to be without being experienced. This is easy enough to do, once we see and admit the necessity. What is much harder to do is to establish some logically intelligible and clinically useful form of continuity in meaning between conscious and unconscious anxiety, so as to justify the usage.

Besides saying that anxiety—of the conscious kind at least—is a felt state of mind, what else can we say of it? For one thing, anxiety is generally an unpleasant feeling. Heroic souls, to be sure, may speak of the "thrill of danger" and, like Ernest Hemingway on his recent well-publicized African safari, may seek out dangerous situations for the sake of various ego-syntonic satisfactions. But anxiety, as one of my colleagues would say, is "a different sort of

John R. Reid, Ph.D., Professor of Philosophy in Psychiatry, Psychiatric Institute, School of Medicine, University of Maryland, Baltimore, Maryland. Read at the 110th annual meeting of the American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

animal." It seeks us out and we feel a prey to it; and we cannot (in all too many cases) either conquer it or run away from it. For we are ignorant of its sources and unable to prevent its effects. It does not exist in the environment, where it might be physically attacked and destroyed, nor is it the perceptible and localizable property of any thing. Rather, it is somehow in us, pervading our mind and threatening the very citadel of consciousness, of our self-control and self-esteem. While it may within limits be masochistically "libidinized," there is little "thrill" connected with it. Instead we feel divided and weakened and in danger of being overwhelmed and destroyed by forces that are a part of us and yet alien to our inner security, to our self-acceptance and peace of mind.

Still, all unpleasant feelings are not feelings of anxiety; there is, or seems to be, some special differentia that marks off the latter, which has yet to be elucidated. For one thing, anxiety involves a feeling of apprehension, a looking forward without being able to see clearly ahead; a sense of some impending danger that we cannot adequately describe and probably cannot avoid —although we might if only we knew what to do. Hence, the sense of confusion and helpfulness along with the flickering hope that if we knew which way to turn or whom to ask for help, then perhaps we could be saved from the threatening danger—like a frightened child reaching out in the dark for the warm, reassuring touch of his mother.

Anxiety, then, is an unpleasant state of mind marked by inner tension and a sense of apprehension, along with uncertainty as to what is going to happen and with self-doubt as to what we can do, or ought to try to do, to prevent its occurrence. As a state of mind, anxiety is thus fairly complex. While the affective component in it usually stands out (hence the tendency to refer to anxiety as a feeling or affect), the cognitive features and the conative impulses in the mental state are noteworthy and must be taken into account if we are going to understand the nature of anxiety. For in it are impulses to act, but also countermanding inhibitions; there are cognitive references, but their objects are vaguely delimited and uncertainly localized. The mounting tension that grows out of these conflicts cannot be discharged in part because of these confusions, the anxious person being more or less in doubt about the causes of his feelings and the consequences of his actions. Hence, the feeling in anxiety-states, often compulsive and intolerable, that one must do something but doesn't know what, being afraid that any move will be wrong. This state of mind, when the anxiety is severe, is like that of a man living on the edge of a precipice, but the fog generated by his own fears makes it impossible for him to know just how close to the edge he in fact is or how deep in reality is the ravine below, with the result that he is paralyzed, fearing to move in any direction, lest his first step be also his last.

So far we have talked mainly about the experience of anxiety. This, as Freud recognized and as common usage confirms, is the essence of the matter, but as Freud has also taught us, there is much more to anxiety than meets the inner eye of introspection. On this point all clinical observers will, I think, agree. For every day we see patients who may feel, according to their verbal reports as well as the nonverbal evidence, very little or no anxiety. Still, the behaviors and symptoms of these patients indicate that they are suffering from anxiety or are driven by it. How are such clinical facts to be interpreted, so as not to fall into contradiction and at the same time to throw some useful light on their meaning?

One point to notice at the outset is that while anxiety is an experience, it is also much more. It is the complex, multidimensional response of an organism at various levels of integration, or stages of disintegration. It has not only an experiential aspect, but also contains within its indefinite "boundaries" a variable set of overlapping reactions and processes which may be characterized as biochemical and neurophysiological, as well as overtly behavioral and interpersonal. Anxiety is thus not a simple thing, with a definite beginning or ending;

on the contrary, its origins are obscure and its manifestations seemingly endless. Hence, it is extremely difficult, without being unjustifiably arbitrary, to mark off its "essence" and to say that the rest of the events in its context are only "accidents." Consequently, we are often in doubt as to whether we are talking about the causes or the effects of anxiety, or are referring to properties that are, by definition, constitutive of its essential nature. This sort of confusion makes it, in turn, impossible for us to test, experimentally or clinically, hypotheses about anxiety; for we cannot tell what logically follows from the definition of the term "anxiety," and what empirically follows because of the contingent relations in which its referent stands. In such obscurity and confusion, definitional rules may successfully masquerade as natural laws, and empty tautologies gain the scientific credit due only to established facts.

The logical problems here involved are difficult, but they can at least in principle be solved. However, this can be done only by clearly specifying, on the one hand, the semantical references we intend, while repeatedly testing, on the other hand, their applicability to the obscure facts. So let us return to the specific problem of defining the term "anxiety."

Anxiety, like any other emotional reaction, has (I should say) at least three distinguishable aspects: the experiential, the physiological, and the behavioral. We have discussed at some length the first of these, the experiential. Let us now look briefly at the other two components in anxiety, starting with the physiological.

As you know, volumes have been written about bodily changes in emotions, and it seems unnecessary to attempt to review in this paper—even if there were time to do it, which there is not—the many observational facts and experimental results, as well as the various, often conflicting, theoretical interpretations, bearing upon the occurrence and meaning of these intra-organic changes in emotional reactions. Many of these investigations bear rather directly on physiological reactions evidently linked, whether as cause, as effect, or as both, with experiences of anxiety, *qua* felt affect. My purpose here is simply to call attention to this class of reactions and to suggest that for any adequately comprehensive and clinically useful definition of "anxiety," they must be included as essential parts of the referent designated. We do not need to embrace in toto the James-Lange theory of emotion to see how artificial and misleading would be a definition of "anxiety" in purely mentalistic terms, particularly for psychiatric, as contrasted with (say) literary, purposes. Naturally, the intensity of the bodily upset or the extent of the physiological dysfunction that is involved will vary, not only with the history and personality of the patient, but also with the nature of the threatening or stressful situation he faces or imagines he faces, and, more specifically, with its meaning for him in terms of his own security. Also, to what degree the anxiety-reaction is "somatized" and what channel of "expression" is primarily utilized and with what pathological result, if any—these are, of course, further questions whose answers (when they are available) will vary with a large number of factors in a given case. It is this large number of evidently relevant variables, plus our lack of quantitative and reliable knowledge as to their interrelationships at physiological and biochemical levels, particularly in relation to anxiety, *qua* experienced—it is this complex muddle (although gradually, we may hope, it is being somewhat cleared up) that makes it impossible, without unjustifiable arbitrariness, to specify exactly what pattern of somatic changes constitutes the physiological component in anxiety.

If the anxiety is acute and severe, as well as "discharged," freely and diffusely, the physiological changes may resemble those associated with Cannon's so-called emergency reaction—fear in particular. On the other hand, if the "sum of excitations," to use Freud's phrase, or the "transformed" libidinal energy somehow involved in the anxiety is "bound" in this or that conversion symptom or is "canalized" in a particular visceral dysfunction, then the physiological configuration will be quite different. As we know, too, the experimental and

physiological components in anxiety reactions may vary independently of each other and in curious ways may unconsciously "substitute" for each other, as in, for example, those cases in which the intensity of guilt feelings seems to vary inversely with the intensity of somatic symptoms, a "cure" in the psychic sphere signalizing a relapse in the somatic and vice versa. In view of these and many other apparently well-established facts, we can see how impossible it is to describe precisely the nature, the intensity, the extent, or the duration of the physiological reactions in anxiety. What we can say is that (1) such reactions obviously occur and that by neurophysiological discharges, both upward and downward, they evidently mediate the experience of anxiety as well as its somatic manifestations; that (2) detectable and traceable or reasonably inferable changes in the physiological reactions are in some cases roughly correlatable with changes in identifiable sensations, impulses, and feelings; and that (3) the ubiquitous operation of circular or feedback mechanisms results in an intra-organismic situation such that changes either in the experiential or in the physiological components of the total anxiety-reaction will somehow be reflected in or expressed by or correlated with changes in the other components in the anxiety-reaction.

If you have a rationalistic passion for "clear and distinct ideas," then much of this description or speculation must strike you, as it does me, as intolerably vague. But I should like to say about psychiatry what Aristotle said about the subject of ethics, namely, that no educated person would expect discussions of it to be very clear. It will take many more decades of logical analysis and psychosomatic research and perhaps the appearance of a few more geniuses of the rank of Freud before these difficult matters are really understood and can be precisely formulated.

A word about the other and final component in the complex referent which, as we see it, is designated by the term "anxiety." This is the behavioral component. "Behavioral" here refers to behavior in a holistic sense, as when we say that the patient did so and so, as contrasted with (say) his hypothalamus, his adrenals, or his liver. Significantly, it is the patient who (as we say) becomes anxious or defends himself against anxiety, a mode of speaking that makes little or no sense if the nominal subject of the action is some part of his body. Hence, it is misleading, to say the least, to speak of anxiety (or any other emotion) as being "localized" in the hypothalamus, or of the liver as "defending" the organism against (say) fatigue by the glycogenolytic action of enzyme systems in its cells. Such abuses of language involve several fallacies, the most notable being, perhaps, the fallacy of division, in which properties significantly predicable only of a certain kind of whole are nominally predicted of some of its parts, with the result that the verbal form of sense actually conceals nonsense.

At the level of behavior, so understood, there are many actions that are in given contexts usually interpreted as "expressions" of anxiety—far too many to discuss here or even to list. But, rather typically, these actions are of the sort called "withdrawing from" or "running away from" some source of danger, except where "opposite" needs or impulses, such as the need for self-approval or the impulse to destroy, make for internal conflicts expressed as "runnings back and forth," literally or symbolically, and other behavioral signs of confusions, uncertainty and ambivalence. Since often the patient does not know what he is afraid of, and hence where it is located, his behavior often appears to be (as it is in fact) random, inappropriate and maladaptive. Particularly in the early stages of anxiety, before exhaustion ensues or defensive reaction-formations are built up, the patient may, for example, more or less literally wring his hands, pace back and forth, or run around in circles—thus at last discharging some of the energy "let loose" by his anxiety and threatening to overwhelm his ego, without, of course, resolving his inner conflicts or really solving his problems. We see, too, in such patients the acting out of anxiety-ridden impulses, whose

motivational significance is not understood, as well as the overt manifestations of different kinds of defense-mechanisms, such as over-compensation, projection, displacement, and so on, against anxiety.

Obviously enough, with respect to this behavioral component, too, no precise limits can justifiably be fixed, by definition, on the range and variety of behaviors that are to be called "expressive" of anxiety. For the meaning of any piece or phase of behavior is contextually determined and can only be adequately understood by the study, with appropriate tools, of the events in this context, whose limits may extend far into the patient's past history, both covert and overt, as well as far into his current interpersonal relations. Anxiety is where you find it and frequently where you do not; for it lurks, as Freud said, behind every symptom and it motivates every defense against itself.

So much by way of indicating in general outline a definition of "conscious anxiety." Let us now turn our attention more specifically to the still vaguer concept of unconscious anxiety. As we have seen, if by definition an essential part of the referent of the word "anxiety" is a certain kind of feeling, whether or not consciously directed toward any particular object, then there is not strictly speaking any such thing as unconscious anxiety. For on this definitional assumption, "unconscious anxiety" would imply "unfelt feeling," which, being self-inconsistent, is the name of nothing—in which only logicians wittingly take much interest.

It might be argued that this is not so, any more than it is necessarily self-contradictory to speak of an "unseen color." If we can intelligibly refer to (say) "the yellow and red of autumn leaves," whether or not perceived by anyone, now or ever, why can we not speak of "unfelt feelings," or of a feeling of anxiety not consciously suffered? Logically this would seem to be possible if we can define "anxiety" as designating a certain kind of sensory complex, a kind of identifiable gestalt, without including in the referent any particular kind of conscious ego-response to it, such as wanting to withdraw from it, or trying to change it, or altering the objects that stimulate it or the conditions giving rise to it. In short, is the subject's conscious attitudinal response to any specific content a necessary part of the referent of "anxiety"?

Such a question is impossible to formulate with a high degree of semantic exactitude, but it is nevertheless crucial logically, and I think the answer to it is plainly "Yes." For it seems to me that to speak of a psychological gestalt as including a feeling of tension with at least a vague reference to some impending danger, even though the anxiety is free-floating or objectless, involves a reference both to cognitive and affective responses in a subject. In short, anxiety is a subject-object complex, whereas yellow is not, in the same sense. This is true, even though we hold that, in fact, every instance of actual yellow causally presupposes an organism with (say) normal color vision, who is making certain neurophysiological responses to a certain pattern of electromagnetic energy, etc. The logical point is that while yellow may in fact involve such intraorganic or even conscious perceptual conditions, the referent designated by "yellow" does not, by definition, involve them. Otherwise put, yellow "could"—it is logically possible, whether or not, in fact, it ever is—still be yellow, as a distinctive kind of hue occupying a certain place between red and blue in the circular order of hues, whether or not anyone sees this hue. But anxiety would not still be anxiety if no one felt it and, more specifically, did not react to it (or its "object" when it has one) in a negative or avoidant manner, or did not respond as if it were a sign of danger, whether the danger is said to be within or without the organism. To deny this is to commit "the fallacy of changing the subject" (as C. I. Lewis has called it): it is in effect to set up a different definition of the word "anxiety" and in this case it would, I think, have to be an arbitrary one not sanctioned by common usage, without making it clear what one is doing. It is as if I denied the analytic statement that "every circle has a center" because I have tacitly rejected the usual definition of "cir-

cle" and have set up a private one, without notice and without justification.

But while some negative attitudinal response may be integral to the anxiety-gestalt, we have not proved that the needs or wishes or impulses—the dynamic reaction-tendencies which are in conflict—are necessarily conscious. Nor do I think this can legitimately be done. For, unlike feeling or affect, the semantic rules of our language do not require us, on pain of self-contradiction, to avoid speaking of impulses or needs or wishes as existing and operating outside of awareness. This is very obvious as regards needs but is equally true, in many contexts, as regards wishes and impulses. For everyday usage, as well as more technical usage in psychology and biology, shows that we recognize the fact that these motivational components in behavior may exist and function unconsciously. They do this in the form, usually, of recurrent vectors in behavior whose magnitude and direction vary with a large number of other factors, which may in turn be classified as genetic or maturational, innate or acquired, morphological or functional, id forces or super-ego forces, and so on, for of the making of many classes there is no end.

Thus, it seems that we can self-consistently and with fair intelligibility say that when we speak (loosely, as Freud recognized) of "unconscious anxiety," what we mean, in more exact language, is that certain features of the patient's behavior, usually both overt and covert, indicate the presence in him of motivational vectors that are in conflict, with the implication that if the relative strength of these conflicting forces were altered, then the patient would experience conscious anxiety. In other words, "unconscious anxiety" is a dispositional predicate that designates certain potentialities of becoming, if certain negative conditions are altered or certain positive conditions are fulfilled.

For example, a patient may, at the beginning of analysis, experience no conscious anxiety. But later, his neurotic ego-defenses having been weakened by the analysis, he may develop symptoms of acute anxiety. Or a patient with phobic tendencies may keep his anxiety under control—out of consciousness—by avoiding certain kinds of situations that possess for him unconscious pathogenic significance. Or another patient, under internal conditions of physiologically caused tension, in say the estrogenic phase of the menstrual cycle, may react with a variety of symptoms, which are autonomically mediated; but if the woman is hysterically inclined and has a number of heterosexual problems, these symptoms are also aggravated and complicated and may be rendered intractable to medicinal therapy because they exist in part on a psychogenic basis. In all such and many other familiar kinds of cases, we may say that the patient's symptoms or difficulties in living are in part caused by unconscious anxiety.

According to our interpretation, this way of speaking means what is best formulated as a number of conditional, if-then, statements, such as: if the intrapsychic balance of forces in the patient were altered—if the defensive forces of the ego were weakened, or if the ego were overwhelmed by some environmental threat, or if emotionally charged impulses, usually sexual or hostile, were sufficiently augmented in strength—then the internal psychic equilibrium of the patient would be upset in such a way that the underlying conflict would break out into the open and the potential anxiety would be actualized and consciously suffered.

Thus, to say that a patient is unconsciously anxious is logically somewhat like saying that he is unconsciously awake, when what we mean is that he is asleep. For as in sleep the ego withdraws certain of its object cathexes, becoming unaware of its environment and body, so in a repressed or dissociated state, expressive of neurotic conflict, the ego becomes unaware of the meaning of certain impulses or wishes and through the defensive operation of projection, displacement and so on, may in varying degrees misinterpret and so conceal from itself the actual structure and causal significance of its perceived environment. But when we say that a person is sleeping normally, we imply that he can be awakened in such and such ways—by applying

certain stimuli. We might represent this fact by saying that he is unconsciously awake—a very different meaning, operationally, from saying that he is overwhelmingly sedated, or is in insulin coma, or is in fact dead. Likewise, when we say that a patient is unconsciously anxious, we mean that by applying certain stimuli or if nature performs, indifferently, certain "experiments" upon him—he will become consciously anxious.

Thus we see that the appearance of flat contradiction in characterizing a patient's condition as involving unconscious anxiety may easily be avoided by the logical procedure of translating and appropriately expanding the usually misleading shorthand of psychoanalysis. This shorthand, which is constructed by substituting brief categorical assertions for longer conditional propositions, may, it is true, not be misleading to clearheaded and theoretically sophisticated experts in the field. Few of us would willingly dispense with some forms of jargon, and many kinds of ellipses function helpfully as convenient labor-and-time-saving devices in everyday communication. When we are talking casually with intimates or are discussing professional matters with fellow experts for whom the implications of our speech do not need to be carefully spelled out or the apparent contradictions in our statements cleared up and eliminated, it would be a foolish and self-defeating kind of logical pedantry to insist that we always make clear and explicit various meanings that may be left, quite harmlessly, in their usual state of vague muddle. For, as some cynic has said, a meaningless noise divides us least, and friendship, at the conversational level, seems often to require that we leave our exact intent sweetly vague. But in theoretical formulations or scientific communications, different criteria of appropriateness and adequacy should apply, and different standards of rigor and precision should be upheld. Under such conditions, stipulating explicitly our definitions and stating precisely the implications of our statements is a logical necessity and, if one likes that sort of thing, need not be a tedious bore.

Our explanation of the meaning of "unconscious anxiety" has so far been couched in terms of potential changes in the patient's feelings—if such-and-such antecedent conditions are fulfilled, then certain consequences will follow, the consequences in this case being emergent forms of conscious anxiety. But since anxiety is something that disturbs the patient's cognitive and impulse life as well as his affects or feelings, as such, a part of the meaning of saying that a neurotic patient is unconsciously anxious may be such things as, for example, that he cannot recall what he knows well, that he can no longer concentrate on any problem involving the slightest difficulty, and that he makes obvious mistakes in reasoning; or that he has become painfully inhibited at social gatherings, that he is chronically undecided and cannot wholeheartedly commit himself to any course of action, and that nothing any more, neither his work nor his home life, gives him real satisfactions. But these are only a few of the innumerable disturbances in the life of thought and impulse that are probably in part manifestations or derivatives of underlying intrapsychic conflicts.

However, the problem is even more complicated than this suggests. For what is meant, vaguely but commonly, by "unconscious anxiety" is a nuclear disturbance of the personality with such pathogenic force, having such varied and extensive ramifications, that the entire organism is morbidly disturbed. In such patients, we observe a wide variety of physiological dysfunctions, conversion symptoms, behavior disorders, and so on, ranging from the conceptually isolated cell to the person as a whole, and more and more of these pathological phenomena are being related, by dynamically oriented physicians, to anxiety in its myriad forms and to the defenses that the organism builds up against this anxiety. Thus, all too literally, anxiety is not only the central problem of psychiatry, but of human life generally; and the "age of anxiety" is every age in which men, who cannot survive apart, huddle anxiously together, though often fearing each other more than they fear the indifferent forces of nature.

Our formulation of the meaning of "unconscious anxiety" does not, I believe, imply any specific answers to questions about the energy relations between conscious and unconscious anxiety. Still it may be said to raise several questions. For instance, if a patient's defenses are analyzed and as a result his conscious anxiety is at least temporarily increased, does this mean that his unconscious anxiety is reduced? Or if a patient uses repression as a defense and thus reduces conscious anxiety, is his load of unconscious anxiety necessarily increased? In general, is there an inverse relationship between the "amounts" of conscious and unconscious anxiety?

I do not think we understand clearly enough the meaning of these questions, and in particular their vaguely quantitative implications, nor do we know enough about the presumably relevant empirical facts, to enable us to answer, with justified confidence, these questions. But if I were forced to give an answer, my inclination would be to say that there is not an inverse relationship between conscious and unconscious anxiety. Unconscious anxiety is directly related to the number and intensity of unconscious conflicts—a statement that is almost, but not quite, tautological. But the occurrence of conscious anxiety depends upon, and its intensity varies with, many other factors, both intraorganismic and environmental, than the "amount" of unconscious anxiety. Blocked drives toward food ingestion or sexual discharge, "sufficient" increases in thyroid and adrenal secretions, changes in environmental factors, like temperature or atmospheric pressure, beyond certain limits, all these and similar variables are related, indubitably but surely not simply, to the occurrence and intensity of conscious anxiety. Such factors are, of course, also related to various "tensions" and forms of internal stress. Whether these latter in some instances "add up" to something we do, or ought to, call "unconscious anxiety" is a nice definitional question.

Freudian usage, while not precisely fixed, tends to restrict the application of the expression "unconscious anxiety" to those cases in which the syndrome in question is interpreted as due, at least primarily, to psychogenic conflicts that are mediated by symbolic factors, some of which have been repressed. This definitional restriction explains in part the further tendency to assume that unconscious anxiety is "neurotic" anxiety.

Now it may be plausibly argued that every "difficult" forked-road situation we face in life, where internal drives and external demands force upon us a decision, may arouse more or less conscious anxiety. But is this anxiety always in part "neurotic" because mediated by repressed ideas? Some analysts would, I think, say "Yes." However, this is surely not always true to any clinically significant degree.

If this be granted, then it follows *a fortiori* that such repressed ideas may contribute very little indeed to the intrasomatic tensions and stresses connected with the intensity and duration, to say nothing of the less simple configurational properties, of a large number of stress-inducing factors (of which we have given a few examples above) that may be "located" both in and outside the organism. How such environmental and intrasomatic factors are in turn related to the kinds of endopsychic factors about which analysts, in spite of their medical training, mostly talk, this is, it seems to me, the most basic and difficult question in psychosomatic medicine.

This large question I cannot discuss here, but I do want to express the logical homily that if we use the term "unconscious anxiety" to cover every conceivable kind of tension or stress or even "primitive form" of vigilance that a person exhibits or suffers, from the cradle (or even before) to the grave, if we thus try to refer to nearly everything by the term we shall end up by saying practically nothing. We need to remember the elementary logical point that intension, roughly speaking, varies inversely with extension. Otherwise, in our anxiety to omit nothing relevant in any connection from the meaning of the term "unconscious anxiety" we shall defeat the purpose of communication and say nothing. In this, as in other fields, we must divide in order to conquer—or even to know what we are

talking about. Just where it is best to divide is of course the recurrent question. Unfortunately for those who want to generalize, the answer to this question requires a judgment of practice that can intelligently be made only on the basis of a knowledge of the specific purposes and the particular facts that are relevant in a given context of use. In any event, humility seems to be indicated, for as Aristotle said, it is hard to "carve nature at the joints"—particularly in psychiatry, we might add, where the very existence of "joints" may be doubted. Still, it would be premature to give up the ghost and turn the required carving job completely over to the orthopods.

By way of summary and further clarification, we may say that from one standpoint, "unconscious anxiety" is an as-if concept. The patient behaves, verbally and nonverbally, as if he were consciously anxious, or as if he were afraid that unless he is very careful and watches his step he will feel anxious. This means, of course, that in fact he is already anxious, the idea of future anxiety mediating its present arousal, but will not quite admit it or he has somehow disguised from himself his real condition. But anxiety, like murder, will out. Indeed, when frank, it literally transpires at every pore; for if the neurotic lies to himself, his body does not lie to others, if they are equipped by native acumen and psychiatric training in the arts of detection and can understand its "language."

"Unconscious anxiety" may also be called, from a slightly different standpoint, a dispositional predicate that expresses an if-then concept. For though, by definition, the patient does not actually feel anxiety, still he is disposed to anxiety and will feel it if certain antecedent conditions are fulfilled. These antecedent conditions may be such sequences as, if this patient is put under more interpersonal stress by, for example, losing his job and being divorced by his wife, or if the vagal hyperactivity that is aggravating this patient's gastric ulcer is not adequately controlled, or if the repressive mechanisms operating in this patient's symbolic behavior are interpreted to him, then in each of these cases the patient will probably suffer conscious anxiety, or more conscious anxiety. As these examples suggest, the factors—social, physiological, or psychological—that bring about or mediate the outbreak of or the increases in anxiety may, and of course do, vary from case to case, as do also the forms of the resultant anxiety and its various psychopathological features. But the logical principle involved in the usage is the same: if something happens in the significant interpersonal relations of the patient, or if certain changes, which may be pathogenic, occur in his body —for example, the growth of a pheochromocytoma—or if some "economic" shift occurs in the relative strength of his unconscious cathexes, then the balance of forces controlling the emergence of the affect of anxiety probably will be altered in such a way that anxiety will be consciously suffered.

Such so-called "dispositional predicates" are common enough in our language and, for future-oriented animals like ourselves, serve a useful purpose. No one objects to "educable" or "malleable," or similar terms, when employed in appropriate contexts. Yet from an operational standpoint, what these predicates logically do is refer to certain "eventual" properties, aspects or signs which will probably enter into direct experience if certain operations are performed or, more generally, certain antecedent conditions are fulfilled. All we are justified in logically demanding is that the relevant antecedent conditions and probable experiential results be specified as adequately and clearly and unambiguously as possible, in view of (as in this present context) the inherent obscurity of the subject-matter. When the problem is looked at in this way, we see that "unconscious anxiety," while a vague expression with many different shades of meaning, is still not in principle illogical or unscientific. On the contrary, when used with due circumspection it makes a good deal of sense and serves, probably as well as any other brief expression, a number of important clinical purposes.

Like (and also unlike) the case of "malleability," we should notice that a highly significant part of the total set of antecedent

conditions sufficient to bring about the actual occurrence of conscious anxiety, in a patient with unconscious anxiety, exists inside the organism. This "part" consists of more or less cyclical, need-reinforced impulses, which actively seek expression and discharge. Thus, unconscious anxiety is a dynamic thing which has to be dealt with somehow, willy-nilly, through the unconscious use of ego defense-mechanisms and by various circuitous and disguised forms of tension-reduction. A person with unconscious anxiety is not just inertly waiting for outside forces to stir him up before his anxiety "breaks out," as the piece of malleable iron presumably is inertly "waiting" for the hammer to beat it into a different shape. On the contrary, such a person seems to "look for" or "to create" occasions to justify his anxiety; he displaces and projects all over the place; and in a masochistic, accident-prone, self-destructive fashion he may expose himself to real dangers or commit real crimes for which he then somehow regularly manages, however inefficient the police force, to be caught and punished. So that while, in a logical sense, the conscious phase of the anxiety in such a case may be merely potential, still, in a psychological sense, the anxiety is highly kinetic. Indeed, it is the systematic emphasis on this latter fact that makes Freud's theory psycho-dynamic, and it is the detailed explanation of how this unconscious anxiety "works" in different personalities with various forms of mental disorder that makes Freud's theory so useful in practice.

Let us return for a final semantic point. We have in one or two places spoken of unconscious anxiety as potential conscious anxiety. The metaphysical problem of potentiality has become notorious in the history of philosophy and still causes many psychogenic headaches. Hard-headed positivists, particularly, dislike the notion and have tried in various ways to "reduce" it to present and future actualities, or even more stringently to "given" impressions of these and their immediately grasped interrelations. There is no time to enter into these obscure debates. But our formulation of the meaning of "unconscious anxiety" avoids, I hope, most of the empty verbiage that can be avoided while sticking to the subject. For the "potentiality" in question refers in part to the feeling of anxiety, and a reference to this, while vague, is certainly intelligible, partly because it is so often fulfilled in our own immediately present feelings of anxiety. But the term "unconscious anxiety" also refers to perceptually get-at-able public facts in the patient's behavior and physiological reactions, and in particular to observable deviations in these from some assumed norms. Such facts, as they are recurrently exhibited in the overt behaviors, both gross and symbolic, as well as the intrasomatic reactions of "anxious" patients, constitute the perceptual basis of the inferences we make both to potential future conscious anxiety and to actual present unconscious anxiety. This "perceptual basis" in a given case may or may not be adequate to support the inferences based upon it. But surely it is sometimes adequate and can in principle always be made more adequate by getting more and better data, in the relevant empirical areas, and by subjecting these data to more rigorous logical processes of evaluation. Thus, by knowing better what we mean and what we observe, we shall know better what to expect and how to facilitate or prevent its occurrence. This is the path of science and of common sense, and no other path, on the available evidence, is open to any of us who seriously desires to advance the science or to improve the practice of psychiatry.

DISCUSSION

HAROLD KELMAN, M.D., New York, N. Y.

Dr. Reid's thesis is that there is unconscious anxiety and that it is a useful concept. For me what he says by implication and toward the end of his paper is more important because it relates to the nature of anxiety in general. Also, I do not feel

he proves his original assertions. He is aware that he starts out with the handicap of the dualism conscious-unconscious. He attempts to extricate himself from this self-created dilemma by if-then and as-if propositions, as well as by resorting to the static concept of potential anxiety, but I do not feel he succeeds. Dr. Reid and I have many points of agreement. However, our starting points of investigation and focus of interest are different. What he puts in small letters and at the end, I put in capitals and at the beginning. Dr. Reid starts with a special case, unconscious anxiety and what is unknown; I start with anxiety in general and with what is known and knowable. I assert anxiety is, then ask what is the what and how of anxiety here and now? We live in the ever-enduring present, much as we might recall of the past and imagine of the future. The always now is ever present to be investigated, and as we do our horizons of knowledge are extended backward and forward in time and space, as well as spatially sidewards and in depth.

From different starting points Dr. Reid and I conclude that anxiety is a multidimensional response of an organism at various levels of integration. I agree that the data essential to form a picture of anxiety are what are observable by an outsider and the patient—biochemical, neurophysiological and behavioral—and what is introspected by the patient—his communicated awareness of his feelings, thoughts and wishes. I agree with Dr. Reid that anxiety is a subject-object complex. But again only at the end does Dr. Reid say a patient may be considered to be anxious whether he is aware of it or not. The central question is not: Does the patient feel anxious? But: Is he being anxious? Using a holistic—multidimensional—definition of anxiety, it is not required that all aspects of the definition be fulfilled for an observer to say the patient is being anxious.

Much confusion in the literature derives from two sources. One is an insistence on a solely subjective or objective definition of anxiety, or one requiring that all aspects of the holistic anxiety response be present before a patient is said to be anxious. The second confusion arises from not clearly distinguishing anxiety from fear. A patient is being anxious and he feels fear. Also, failure to question patients closely leads to the too-quick conclusion that they are not feeling anxious. They may be using different words to describe their anxiety, be describing certain aspects of feeling anxious, or be governed by a very private conception of what is feeling anxious. Likewise, at a later point, patients will tell you they had been anxious but could not find words to express the feeling or for neurotic reasons could not mention having the feeling. Then there are those patients who are obviously being anxious but do not feel anxiety because their neurotic blocks to feeling their feelings are so intense they have become dulled to their own feelings. Also, the observer may not be careful enough in his investigation—in noting what is and could be observable.

I therefore conclude that much that has been subsumed under unconscious anxiety is not unconscious but a reflection of inadequate and inaccurate questioning and observation. And Dr. Reid says something similar on the last page of his paper.

In attempting to formulate a unitary theory of anxiety I felt a more comprehensive picture of anxiety could be obtained by asking what is anxiety, what are the sources, what are the functions of, what are the attitudes toward, anxiety? Then I asked what proportion of the anxiety is rational and what irrational—as to sources, functions, attitudes, intensity and extensity. By rational and irrational I mean in and out of ratio with the actualities. Rational is not synonymous with mental, logical or healthy, but subsumes them all and more. And here again Dr. Reid and I meet in one of his incidental remarks, where he questions whether anxiety is "always in part neurotic because mediated by repressed ideas. Some analysts would, I think, say 'Yes.' However, this is surely not always true to any clinically significant degree."

I would say anxiety is natural—it is in the nature of human beings to be anxious as it is in them to feel fear, joy, anger, sorrow. Anxiety is not good or bad per se,

but the proportions of anxiety may be more and less rational and irrational. For with Goldstein, I agree that the organism manifests minute anxiety responses in its moment-to-moment attempts to become adequate to its environment, and that a measure of a creative person is the daring to chance anxiety for possible growth. This is not a masochistic welcoming of pain. In fact the pain we have anyway, the sicker we are—and without the gain. This is a choosing of pain when it is foreknown and unavoidable but with the hope of creative gain on the basis of previous similar experiences. And with such courage many pioneers have voyaged into the unknown sea of anxiety and foundered. Dr. Reid's voyage I feel has been fortunate in coming off with so few bruises and a substantial part of the ship still intact.

COMPLETENESS—INCOMPLETENESS

THE HUMAN SITUATION

CHARLES R. HULBECK

AGAIN and again in psychoanalysis we meet with topics that are hard to tackle and harder to define. Therefore the problem of methodology should play a major part in explaining psychoanalytical material. As far as completeness is concerned, I am fully aware of the difficulties involved. Since this is so, we just will have to plunge in and come back to a consideration of methods while we are talking about our topic.

Karen Horney, talking about the Idealized Image in *Our Inner Conflicts*,[1] speaks of the major neurotic attitudes toward others, through which a person may attempt to solve his conflicts or, "more precisely, dispose of them." She continues: "One of these consists in repressing certain aspects of the personality and bringing their opposites to the fore; the other is to put such distance between oneself and one's fellows that the conflicts are set out of operation." And later: "A further attempt is the creation of an image of what the neurotic believes himself to be or of what at the time he feels he can or ought to be." Later she says that this phenomenon of the Idealized Image has long been recognized. She quotes Freud, who calls it Ego Ideal, Narcissism, Superego. According to Horney it also forms the central thesis of Adler's psychology and is described there as a striving for superiority.

Completeness-incompleteness is a pair of opposites we find in all personalities, healthy and sick alike. It is a basic pair of opposites and therefore a definite expression of every personality. Only in certain cases, in which a person expresses only a part of it, does it form an aspect of neurosis. Completeness-incompleteness therefore relates to the whole of the personality. We assume it to be present at all times and to be seen in many forms of behavior. The Idealized Image may be manifest in these patterns but not necessarily.

The ways of understanding the deeper meaning of human personality can be different. Freud's personality concept is somewhat like a release that comes about after an adjustment of the Ego in its precarious situation between the Superego and the Id, two powerful forces, always ready to submerge it. Freud's psychology of survival, which David Riesman in his book *Individualism Reconsidered*[2] calls "scarcity psychology," is different from a psychology that assumes the potential presence of such pairs of opposites as completeness-incompleteness. While all writers on human psychology try to elaborate "irreducibles," as Sartre calls them—the basic attitudes from which personality can be explained—the way for a personality to reach full status is different according to different theories. There seems to be a difference between a personality

Charles R. Hulbeck, M.D., Berlin 1922; Lecturer in "People's University of Danzig," and "Humboldt Academy," Berlin; Assistant Psychiatrist, New York University Clinic; Assistant Director, Brooklyn Child Guidance Clinic. Lecturer, American Institute for Psychoanalysis and New School for Social Research. This paper was read before the Association for the Advancement of Psychoanalysis at the New York Academy of Medicine, February 23, 1955.

that develops in time and a personality that is always potentially there. In Freud's basic concepts man is a creation of the past. Horney's man lives first in reality. The functioning of opposite trends such as completeness-incompleteness is related to a personality in a "situation," or better in a present situation.

Philosophical thoughts that overlap into psychoanalytical ideas often have to be translated into psychoanalytical language in order to help us realize that many of our psychoanalytical terms are derivatives from philosophical and religious ideas. We still operate with God and the devil, and for some reason we declare a certain value to be God and another to be the devil. Cultural and parental conditioning play an immense role. In neurosis, anxiety drives a person to repress one part of the opposites and declare it to be the devil. What one has to learn, though, is the fact that God cannot function without the devil and vice versa. Completeness cannot function without incompleteness and vice versa. A personality "in full" is able to use both in its intricate relation. We do not know how the opposites work together. The disturbance of their relationship is more familiar to us than their cooperation.

Psychoanalysis has been based on genetics in the sense that we assumed with Freud the logical determinism of all psychological phenomena. The concept of genetics is based on a form of linear cause-and-effect theory. One generally thinks that the earlier and more distant the cause of a phenomenon, the more important it is considered to be. Consequently, Freud assumed that personality as it presented itself to the clinician was something composed of many cause-and-effect chains that may be traced back to the very beginning of human existence.

If in this sense, a man is a masochist, his masochism must be caused by something that happened to him many years ago. The effect of this "trauma" makes itself felt in many transformations throughout the years until it emerges as masochism in its present manifestations.

The idea of opposite trends, working together and against each other, finds its convincing demonstration mostly in the present, though each of these trends or part of them may be traced to early experiences. In other words, the present performance of the patient in a "situation" assumes the same importance as the "cause," such as was described. The difference is obvious. A house as a phenomenon may be described as a pile of bricks and steel, as a conglomeration of different materials, the origin of which contributes to the knowledge of the house. But the house is also something to live with and to live in. The house has an immediate performance as it has a historical one. Both aspects seem to be equally important if one knows that the "present performance" yields insight as much as the historical one.

Here is another illustration. If we see a person playing a role on the stage, we are primarily interested in his immediate and present existence and we value him according to this immediate impression which corresponds with his abilities. We are only secondarily interested in the man's history, what brought him to acting, where he comes from, why he does what he does at this moment. The phenomenological part of this man's existence (Husserl)[3] is as important to us as the historical one. From a phenomenological point of view a man on the stage is worth to us as much as he shows to us.

Husserl's fight against what he calls "psychologism" has its source in the overrating of the cause-effect device. In other words, while we can explain things through the common machinery of logic, the present performance of a phenomenon is independent of cause and effect. This performance can be compared with the performance of an orchestra in which different instruments work together for the artistic effect. This working together has played a great role in modern art and in modern philosophy, as has the concept of simultaneity. Opposites, such as completeness-incompleteness, can be understood from the concept of simultaneity. Completeness as well as incompleteness—antagonizing each other and supplementing each other—work simul-

taneously like instruments in an orchestra performance.

The simultaneous working of the opposites has to be understood as a personal experience, different in each person. While the opposites are characteristic for all human beings, they are personally experienced in the sense that their occurrence is subjected to special circumstances. The parental and cultural background assume great importance. Completeness-incompleteness, in their appearance as personal expressions, are very much an outcome of cultural and parental conditioning.

The concept of simultaneity in contrast to what was called the cause-effect device, and in contrast to what may be called chronicity—a thinking that traces forth and back on a time-line—is nothing really new.

Modern physics has been operating with simultaneity. The constancy of the speed of light could symbolize the constancy of personality branching out in different directions.

Goldstein and Gelb's[4] experiments show the human body to be able to synthesize separate elements even if one or the other is lacking. This shows the building quality of what is called the psychosomatic machinery of the body. The body and the mind work together constructively to create one whole and necessary effect. What is true with seeing is true with feeling, with acting. "Gestalt" psychology made this the basis of its thinking, giving its main emphasis to the unifying and forming ability of the human mind.

As much as other opposites, completeness-incompleteness work as variables in relation to the constant quality of personality. Or, personality is the regulating agent of opposite variables. Simultaneity is the constructive or creative quality of the human mind which enables it to experience opposites together.

The objective fact of opposites should be separated from the subjective experience. The opposites, being universal facts, are experienced subjectively and projected into time and space. As soon as a personality has lost its constructive ability, the opposites fall apart or substitute for each other. Either completeness or incompleteness is chosen compulsively, following the line of conditioning. As there is no real difference between outside and inside, it does not matter whether the reason for the disturbance comes from "complexes" or from cultural coercion.

The composing of the opposites is the very essence of creativity.

Personality works in opposites and the simultaneous working of the opposites constitutes the dynamics of the personality. The term dynamics is used as an "expressive" force and consequently one may say that personality expresses itself by the dynamics of the opposites.

These dynamics we call growth. A personality grows if it is in possession of the dynamics of the opposites. Growth means expanding one's limits or transcendence. Transcendence is accompanied by many psychological elements, such as imagination, intuition, courage and others. If one follows the pattern defined by Sartre[5] in his *Existentialist Psychoanalysis* as "Initself" and "Foritself," one possesses and is possessed, as he demonstrates it on "slime." In other words, one gets involved. There is, therefore, an intricate relation between personality, growth and the dynamics of the opposites.

Following the usage of ordinary language one would say that completeness has something to do with termination, perfection, exactness, something good that can be accepted by others. One completes things to satisfy oneself and to satisfy others. One strives for something that is solid beyond question and as an achievement is bound up with prestige. Completeness has an individual and social meaning. We ask for completeness in our work because the idea of completeness is embedded in our personality, and we feel guilty without completeness. As one is supposed to complete things, persons who do not do so are criticized and lose prestige.

The work of an architect might help to make completeness more understandable. If an architect builds a house, we judge the house and the work of the architect from the standpoint of completeness. We think

an architect is a good architect because he planned the house well and thought through all the problems involved. If he had stopped halfway we would not have thought of him as a good architect. We would think that something is wrong with the architect's personality. The architect "must" complete the house because only a complete house can be used by people. Completeness is clearly related to the architect himself. Only a complete architect can build a complete house. Consequently, completeness in everyday language means to make a thing useful for ourselves and others. This concept encompasses the idea of serving, contacting, participating. Only a person who can serve us with a complete thing, a complete achievement, is a social asset.

While we complete and make ourselves useful we ourselves grow and in the respect of others. Satisfaction is therefore intimately related to growth. Through achievement we are different from what we were before. This difference we connect with the idea of transcendence. Transcendence means that through contacting the "other" with achievement we are crossing the limits of ourselves. We expand our personality. We go into a new area, into a new land and in many ways also into no-man's land. So, the completed thing brings about unforeseen development of our personality. One may also define personality as a form of development caused by striving for completion.

Participation, the move of the "Foritself" toward the "Initself," has a social meaning, but it also shows the progress of the personality developing from immaturity toward a higher form of living. If personality can objectivate itself by completeness it can participate and be with "the other." Such a personality has found ways and means to experience human relationship maturely.

In psychoanalysis the process of cure is dependent on completeness. The analyst wants to complete the analysis as much as the patient. Both make an effort toward termination, though they are held up by the vagueness of the process and the absence of objective measurement. In the case of the architect, the frame of reference is the usefulness of the house; in analysis usefulness and completeness are not identical. This shows the differences in completeness if applied to different situations, but it is still completeness we are asking for.

If we say a person is "realistic" we mean to say that he strives for accomplishment and completeness. Life, in many ways, is as real as it is complete. We say that a person lived a full life, which not only means that he fulfilled himself but also that he completed it. Death, religion says, is the final completion of life.

The expression "consummating something" indicates our intense desire for completion. We think of friendship or a marital relationship as being real to the extent it can be consummated. If we say that a person lives really, we mean that he lives with an intense desire to consummate life in every respect. We often call such a person a strong personality.

A "strong personality," being able to consummate life, is able to grow, to develop his abilities and to show them through achievements. This means full adjustment to life, and such a person, we assume, understanding the deeper flux of life, does not hold on either to things or to himself. Letting oneself go, being able to desist from control of others, means that such a person understands the needs of his fellow men.

To summarize: The need to complete things is very much with us at all times. This need has become an embedded part of science and religion as well as of our everyday morality. In our morality the idea of completeness has been accepted as a "must." Completeness also seems to fit well into the character of our civilization to the extent that a person who is unable to complete things is driven to pretend that he is able to do so. The idea of completeness therefore is undeniably related to what we call personality and growth and development.

As long as we talk about completeness we are helped by general standards, but the need for incompleteness is harder to explain. We will have to prove that there is a general need for incompleteness as *much* as there is a general need for completeness.

Who is willing to believe that we want to be incomplete? But this is so in fact. The wish to be incomplete is, however, generally unconscious. If it becomes conscious, it is identified with laziness, receding from the goal, giving up and disintegration. The desire for completeness being as strong as it is, incompleteness as something to strive for is brushed aside.

Incompleteness may be understood from general personality development. If one points to the fact that personality development never comes to an end, one is obliged to realize the relative incompleteness of a certain stage. Man, one would have to agree, is relatively incomplete as long as he strives for better and more development.

This points directly toward early youth and childhood development. A child, as generally accepted, is always incomplete and at this stage nobody would criticize it. The child's development, growth and improvement is seen as a stage of incompleteness. There is a general love for children due to the fact that they have not reached the stage of completeness yet. One may reproach a man for "acting like a boy" but "being boyish" might mean something positive.

The preference for the state of *not-being-ready-yet* indicates an unconscious awareness of the process of growth in regard to personality development. This is related to the love of seeing things grow, of assisting someone or something that is being built, of leaving the old and trying something new. While this is so, we find the happiness connected with incompleteness often accompanied by anxieties. These anxieties, as we see it, are induced by cultural standards which again are in a measure responsible for individual complexes.

As culture and morals determine the nature of completeness with an iron hand, we accept incompleteness only to a certain degree, anxiously measuring the distance between completeness and incompleteness in regard to general standards.

If, as many people say, our society is as rigid as it is mechanized, then standards are rigid too. The rigidity of standards is concomitant with externalization, which means that the striving for these standards is neurotically compulsive. The neurotic character makes an either-or situation out of what "must" be obtained. The alternative carries a grave loss of respect for oneself, induced by the lowering of one's estimation in the eyes of others.

Breaking through the barriers of rigidly set standards without a clear insight into the completeness-incompleteness problem seems to be impossible. Incompleteness, under the described circumstances becomes the evil "per se." "If only other people don't see what I do. . . ." As long as other people don't see, incompleteness is acceptable as a temporary state. If standards are considered to be unbreakable, absolute, ready-made, an understanding of development and growth will be lacking. It only will be tolerated if we deal with children, persons whom we consider to be sick or helpless, or animals, who are unable to compete with us and over whom we can easily triumph. The compulsive need to complete excludes insight, judges severely all who do not do as we do, belongs often to a low materialistic philosophy, is ready to use force if objected to and creates an atmosphere for neurosis and psychosis. This total rejection of incompleteness makes completeness very difficult, which puzzles people but does not help them to see things clearer. As we are conditioned toward dualism, the acceptance of an opposite, like incompleteness is considered a crime. Achievements instead of being performed with casualness become a matter of life and death. Suspicion arises concerning anyone who under pressure would like to take things easier. One is only permitted "to take things easy" shortly before a general collapse is expected. Life finally assumes a detective-story atmosphere where everybody hides behind his rationalizations and where anxiety and righteousness are rampant.

Obtaining completion is dependent on what may be called the intelligence of the opposite, insight into the very nature of completeness and incompleteness as a rhythmic alternation in human existence. One cannot love one thing and hate the other and, therefore, one cannot insist on com-

pleteness without understanding the opposite. The neurotic sometimes tries to solve this problem through departmentalization. He loves completeness but he also likes incompleteness a little bit. He likes it as persons like their dogs, or as criminals often attend to canary birds. Here again are creatures with whom competition is impossible. They are only accepted for this reason. We have similar attitudes toward art and other "hobbies." People who otherwise are perfect products of commercialism, holding competition as the best human quality ("it brings out a man's real strength") fall in love with stamp collections, with Picasso, with anything that does not remind them of their compulsive drives.

The machine and its world play a tremendous role in the tragedy of repression, the machine being something never incomplete and always efficient. The application of mechanization as a philosophy of life disturbs gravely the harmonious functioning of the opposites. If one identifies oneself with the efficiency of the machine one may become a robot like the "golem," a Frankenstein monster which, as demonstrated in fiction and poetry, is likely to run wild one day.

Looking for the sources of the completeness-incompleteness tension one should not forget the problem of chance or chance-taking. Chance is an unforeseen reality that defies our intentions. If a man who takes a certain way to his job every day takes another way one day, falls over an orange peel and breaks his leg, he is subject to chance. If a woman who tries to marry and never can, one day is introduced to a man who after a short time proposes to her, she is subject to chance. Chance in this sense is less the conscious chance-taking, the courage to ask for something unforeseen, but rather an event that comes to us through deviation from our common path. Sudden sickness, sudden death and accidents are such chances.

As we do not know what can happen to us, we do not know whether we can complete our work without interference from "fate." In spite of all necessary preparations we are subject to the power of unknown forces. This "unknown" inhibits our steps and is the cause of anxiety. It causes severe disturbance in the completeness-incompleteness relationship. As we do not know what will be tomorrow, we try to complete our work today or we abandon it altogether. We rush ourselves and others ruthlessly, exerting pressure to the point of collapse. We are full of self-pity, misery and often overcome by a sense of futility. Sometimes instead of rushing we procrastinate, we let it all go, we let things "take care of themselves." We let them "straighten themselves out."

A further disturbance seen in the completeness-incompleteness tension is the neurotic grandiosity-inferiority complex. Personalities caught between these opposites stop growing. Transcendence becomes an act of extreme effort. Anxiety has to be beaten back, doubts repressed. More than ever relaxation is considered to be identical with failure, and failure is tantamount to complete disintegration.

Sartre's existentialism touches off many questions in regard to completeness-incompleteness. The similarity between his standpoint and our arguments is obvious. Personality arises from outside and inside conflicts. Sartre rejects the unconscious altogether, with which statement one cannot agree. The experience of transcendence, holding the center in Sartre's philosophy, is entirely a product of human consciousness. Personality is born from this very activity, to transcend, to grow and to contact the "other."

To go into nothingness means to contact "the nothing" within ourselves which is tantamount to the feeling "of being lost" (Heidegger). The feeling of being nothing, of "not being anything yet," is obviously not different from what this author described. The feeling of being nothing, therefore, is not different from the feeling of not being complete or not being a person yet. Personality development, common to all human beings, starts in early youth and is dependent on cultural conditioning. Man is fully able to solve his problem in reality, if he understands the "essentials" and the mechanics of the "irreducibles."

The past and the future hold a quality of directive, which has to be understood and worked on. Personality impresses itself on both, like Rodin's hand on clay or the march of a dinosaur as seen in his footprints.

In Heidegger's "Sein and Zeit"[6] (Existence and Time), time and existence become identical, expressed in human experience. Existence is not the product of a cause-effect chain, but a free creation or self-nomination, lifting man from a feeling of being lost to a self-confident position.

Though many points have been clarified we are not able to define the inner mechanics of the completeness-incompleteness relationship. They are two opposites which at times work with each other and at times work against each other. Normally they blend, and while completeness works, incompleteness is distinctly felt as a supplement. In other words, if we strive for perfection, there is an element which induces the "creative interval," the pause, relaxation, the expecting attitude enabling us to understand the element of chance. On the other hand, in the case of neurosis, each of the opposites may be pursued compulsively, which then leads to a complete repression of the opposite.

The disturbance in the completeness-incompleteness relation, what was also called incompleteness-completeness tension or, vice versa, completeness-incompleteness tension, is seen distinctly in human relationship and especially in the relationship of the sexes. What one may call the male and the female principle are opposites working in a similar fashion. The application of a compulsive drive, either for completeness or incompleteness, may upset the equilibrium of the male-female harmony. This is seen today where due to cultural influences the whole system of opposites has broken down and the development of personality is imperiled.

In the eyes of the modern girl of today, the man she wants to marry has to be perfect, a complete product, as she sees it in the dreams that come to her from the movies, television and newspapers and through parental influences. The man has to be perfect physically (six-footer), financially (millionaire), sexually (supranatural potency) and socially (member of the elite). A prince to such a girl is just good enough and the more one goes down the social ladder the more frequently the desire for such perfection is observed. If it comes to marriage, after great hesitation (because nobody meets the girl's expectations) it is obvious that neither John nor Bill are princes and as the truth that they are ordinary human beings impresses itself, disappointment sets in. This disappointment is one of the major causes of marital discord and divorce.

On the other hand, self-acceptance makes it possible to understand the functioning of incompleteness. What first was considered to be an impediment becomes a part of one's personality. Incompleteness is not looked upon any more as socially prohibited, immoral and dangerous. It is recognized as a necessary part of personality relating to growth and development. Self-realization consists of accepting the repressed parts of our personality (Jung's "shadow"). If a person writes in his autobiography that already in early youth he had no other wish than to "be someone great" he fits very well into the compulsive atmosphere of today but he buys his success at the cost of half of his personality. He becomes a one-sided person instead of a many-sided person. His striving for success is a repressive act, artificial, harmful and brutal. The "natural" rebelliousness, as seen in every child, is substituted for by "adjustment" which by far exceeds the necessary adaptation to reality. He becomes an opportunist, a conformist, as described by Alberto Moravia.[7] He has to be on guard constantly not to let qualities come up that are related to the "dark side" of his personality, everything that could remind him of the "laissez-faire" that made his childhood happy. He thinks of himself as a mature and "realistic" person but is only a rigid puppet in a closed system.

This man, this product, adheres to all the compulsive rules of success: he speaks with a sweet voice, he wears the proper clothes, he does the "right" things, he never

objects, he is a "smooth operator," slick, shrewd and brutal. He kills his enemies with regret and rationalizes his ugliness by having a hobby at home: a dog, sculpture, or playing the piano. He kills and dabbles in art.

What we learn from art in regard to completeness-incompleteness is the fact that achievement, termination, making things ready, have no direct relation to perfection. The diligent artist is by no means the best artist. The Bohemian attitude of many artists is supposed to symbolize a certain looseness of morals and freedom of the mind, necessary for artistic work.

All activities are subject to the rhythm of doing and not-doing, of effort and relaxation, of systole and diastole, of being and not-being. It is the interval that is as important as the work itself. Creative anxiety reveals the need for "the interval" in the work itself (painting), in space-relations.

The fear of starting on empty canvasses, the fear of talking into the dark from a lighted stage, agoraphobia, dreams picturing people falling into space, nothingness, emptiness and boredom—all these symbolize the completeness—incompleteness tension.

Alcoholics often show the effects of completeness-incompleteness tension more than other patients. Their ideas of grandeur are conspicuously set against the fathomless depth of ideas of inferiority. They can never accept their incomplete alcoholic existence and are consequently ridden by guilt. Their expectation of a life of perfection is constantly thwarted by reverses. Tension and disappointment become so great that suicide is often the only solution.

The mental structure of the psychotic who thinks of himself as Beethoven, Napoleon or Jesus Christ can be related to the completeness-incompleteness problem. The ideas of the psychotic may impress us as weird though harmless, but opinion changes when violence breaks out. The terrific tension caused by the difference between completeness expectations and the acceptance of incompleteness may well be the reason for such symptoms.

It is interesting to know that it is not so much the fact that the psychotic idealizes himself as Jesus Christ but that he wishes to be as perfect as he thinks this figure is. It is the completeness of the figure more than anything else that he is intrigued by, and at the moment when he is reminded of his incompleteness violence breaks out.

The neurotic situation is the same but the symptoms are different. Here, the patient has a certain control over his conflicts. He knows that one cannot give a million dollars away if one has only a nickel in one's pocket. The neurotic has some knowledge of the flow of life, about development, transcendence and participation. The rhythm of life works in him though in an arhythmical, jazzy manner.

Freedom, courage, awareness of growth and development, the true relation between subject and object, the ability to express, to take the moment, to realize the present in past and future—all these elements belong to the healthy personality. Completeness and incompleteness become landmarks of a deeper knowledge of existence and recognition of the self.

To leave a space between yourself and the other person that can be filled, this margin of freedom and tolerance, this acknowledgement of the fact, that we are human beings and that all human beings are incomplete reveals a real understanding of the completeness-incompleteness problem. It encompasses an understanding of what has been said about space. The space that sometimes signifies nothingness, the origin, the dark, the point of departure represents the necessary distance between persons. If you leave a space between yourself and others you accept his right to privacy.

Detachment, it has been said, is not only a sign of neurosis or psychosis but also a wish to create space between persons, to be able to watch, to observe and to judge distances. This again is related to space as a part of creativity, whether in regard to people or to objects.

The problem of concentration which in these days is with us more than at any other time (the difficulty in concentrating in a

world of things, the difficulty of making a choice) depends on the recognition of the importance of incompleteness. No intensity is possible for anyone who thinks of himself as being complete and ready or who thinks of objects as being ready.

The problem of change is the acknowledgement of incompleteness, an incompleteness that moves toward completing but will never be completed and therefore will never be terminated. This is psychoanalysis proper. Here we deal with a process that is utterly bent on change, and as the success of the analysis depends on the patient's acceptance of change it also depends on his acceptance of the completeness-incompleteness relation.

To conclude, one could say that the completeness-incompleteness problem is an ontological problem because it mainly deals with the present and with a situation. Only from the present, under the pressure of actual experiences do we branch out into the future or recede into the past, applying completeness or incompleteness notions.

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CONVENTION, CONFLICT AND LIBERATION

FURTHER OBSERVATIONS ON ASIAN PSYCHOLOGY AND MODERN PSYCHIATRY

ALAN W. WATTS

WHEN WE compare some of the trends in modern psychotherapy with certain practical disciplines of Asian philosophy, we begin to discover a most instructive clarification of the whole function of therapy, and especially of its relation to social institutions. Among social institutions we must understand conventions of every type; not only the family, marriage, legal codes, and systems of language, but also ideas of motion, time, space and personality which are generally understood to be properties of the physical world rather than conventions of social origin.* But it would seem that the rigorous procedures of mathematics and physics are confirming the intuition of Indian and Chinese thinkers as to the essentially conventional character of our conceptions of the physical world.

In Indian philosophy the world as we conceive it is termed *māyā*—a much misunderstood word derived from the Sanskrit root *matr-*, "to measure," and from which we have in turn derived such words as meter, matrix, and material. Stated rather baldly, the theory of *māyā* is that the world as we conceive it is a mental construct as distinct from an "objective" reality. This is not to be confused with Western views of subjective idealism. It is rather the more easily verifiable notion that the world as we conceive it (e.g., as a multiplicity of "things" in relative motion) is not to be identified with the world as it is, in the same way that one does not identify the measure with what is measured. One does not confuse the cloth with the yard, since it would be impossible to make clothing from merely abstract yards. Thus a person is said to be spellbound by *māyā* when he confuses the concrete with the abstract, when he is hypnotized into believing that the world of immediate experience is precisely the system of concepts (*vikalpa*) and measures which he employs to manipulate that world, and to make reconstructions of it in terms of the symbols of thought. These concepts and measures are our social institutions, and include, as here defined, so-called laws of nature, ideas of "human nature," of matter, of things, and of events—all of which are held to be fundamentally arbitrary conventions of measurement and classification into which the real world is "fitted" as water is poured into jars, bottles and conduits of varying shapes and uses.

It is as if the real world corresponded to the amorphous ink blot of the Rorschach Test, and the world-as-conceived to the picture which the subject projects upon it. The actual ink blot is *satyam* or *brahman*,

* For this extension of the concept of a social institution I am largely indebted to the work of my colleague, Leo Johnson of Berkeley, California, from research in the field of the history of science.

Alan W. Watts is Dean of The American Academy of Asian Studies, San Francisco, California, and author of many books on East-West relations in religion, philosophy, and psychology, including *The Spirit of Zen* (1936), *The Meaning of Happiness* (1940), *The Supreme Identity* (1950), and *The Wisdom of Insecurity* (1951).

the immeasurable reality, and in this case the "blot" includes both the perceiver and the perceived. The subject's projection upon the blot is *māyā*, but in this case the subject—every individual in a society—does not fabricate his own projection. He learns it from society in the course of his upbringing, and is taught to regard it, not as a projection, but as "what really is."

In every society, Western and Eastern, upbringing and education is the process of learning the conventions, a process which entails many types of difficulty and conflict. For social conventions are like the bed of Procrustes: those too short for it have to be stretched, and those too long have to be cut down. Since all these conventions are in some sense types of language, of symbolic classification and re-presentation of the world, the difficulties in learning them are the same as those encountered in mastering the complex vocabulary and grammar of an unfamiliar tongue.

Here are two immediate sources of conflict. Because every system of "language" is an attempt to represent the world in terms of a static and usually linear system of signs, it appears that the world is, in itself, frustratingly complex. But the complexity lies in the language rather than the reality, and is analogous to the complexity of trying to drink water with a fork. Nothing is simpler than to breathe; it becomes complex only when one tries to represent how it is done in communicable signs, that is, to *think* about it. Furthermore, all such systems must of necessity have a static—because generally accepted—character which makes the real world appear bewilderingly changeable.

Conventional systems necessarily involve rather rigid conceptions of what man is, whether as the knowing subject or ego, as possessing a human nature with more-or-less fixed and "proper" characteristics, or as having a defined role in society which the individual is obliged to identify with "himself." Such concepts do not necessarily correspond with what we feel ourselves to be, in ways which we cannot easily formulate.* This, together with misunderstandings as to what the rules of the system are supposed to be, leads to the most excruciating conflicts between the individual and the system, or rather, between the individual's version of what he is and his version of what the system requires of him. To the extent that he identifies the rules of the system with the laws of nature, or of God, he feels himself to be at odds with reality itself, and to be faced with the choice of an intolerable submission or foolhardy rebellion against "iron facts."

Still another source of conflict is that the confusion of the abstract formulation with the concrete reality leads to the pursuit of goals which, because they exist in the abstract alone, cannot be attained or do not give satisfaction when attained. The ideal of a state of pleasure or happiness unalloyed with pain, or the goal of success, of wealth measured in the symbolic terms of money, are obvious examples of such abstract mirages. So, too, are life-goals conceived in terms of future time, as in the feeling that life is insupportable without a promising future, however agreeable the immediate present.

The idea of motion in time is perhaps the most problematic of all conventions, since it appears to be at once the source of our highest culture and our deepest misery. It is not difficult to see that there is an important sense in which only the present is real, even though constantly eluding our grasp. There seems to be no way of measuring it, of determining how "long" it lasts, and it cannot be regarded as infinitesimally "short" since this would seem to make any experience of it impossible. Likewise we feel that the present experience cannot be held in consciousness, and the more we try to retain it, the more we are aware of its evanescence. But this appears to be a special case of the whole problem of trying to define or measure the real world in terms of conventional structures. The problem of defining or grasping the present is essentially the same as that of trying to write a law without loopholes, or of formulating an exhaustively accurate description of a simple event.

* As witness the intense difficulty of most patients in trying to describe the "peculiar feelings" which occasion their neurosis.

By the convention of time we identify ourselves, collectively and individually, with history, with a linear series of past events projected into a future. This series is conventional not only in the sense that the present alone has actuality, but also in that the events constituting the history are a selection of "significant" events from an infinite possibility, just as there are infinitely many ways of projecting pictures into the Rorschach ink blots. To be identified with a history is to be identified with an abstraction, and thus to have the constant, gnawing sense that one lacks reality, that one is perpetually and ineluctably "falling apart," that one is everlastingly inadequate. But the definition, the description, is always inadequate to the reality. Therefore, to be identified with such an abstraction (e.g., a social role), or, worse, to be *in search* of security in terms of such an abstraction, is to be self-condemned to inadequacy.

The foregoing may sound as if social conventions were under attack. On the contrary, they are the *sine qua non* of human communication, the foundations of all culture. But, like every useful and creative instrument, they involve costs and dangers. There is certainly no doubt that every member of society must be disciplined in its conventions. But it must be recognized that the disciplinary process brings about inner conflicts, and almost inevitably warps that indefinable naturalness and spontaneity which every adult envies in the child.* Therefore certain Asian societies provide optional means for relieving people of the warping effects of their acculturation and upbringing, which give them inward liberation (*moksha*) from the conventions which they have been compelled to learn. This liberation is, however, utterly different from rebellion against the conventions, since rebellion always implies a bondage to that against which one rebels. Liberation enables a man to be the master instead of the slave of his social conventions, and requires not that he condemn them as wrong, but that he "see through them" as arbitrary, like the rules of a game.

The process of acculturation and liberation is reflected in the outward structure of ancient Hindu society. The society as such consisted of four castes or role-groups: *brahmana* (priesthood), *kshatriya* (temporal power), *vaishya* (merchant), and *shudra* (laborer). By virtue of membership in one of these castes an individual possessed an identity. But, whenever he had completed his responsibilities, he might abandon caste to follow the way of liberation, giving up his identity and becoming a *sanyassin*, or homeless monk. The *sanyassin* was an "upper outlaw," just as the Untouchable was a "lower outlaw," for as the latter was beneath the law the former was above it. Ideally, the *sanyassin* was a *jivan-mukta*—one who, though still appearing to be an individual from the standpoint of social convention (*māyā*), is from his own standpoint "no one," since he no longer identifies himself with a role, a *persona*, but with concrete reality, which is nonconceptual (*nirvikalpa*).†

In Chinese society, the process of acculturation is represented by Confucianism, and of liberation by Taoism or Buddhism, since the typical Taoist is the old man who has retired from the world to live alone in the mountains.

> I will cast out Wisdom and reject
> Learning.
> My thoughts shall wander in the
> Great Void.[1]

In common with the *sanyassin*, the Taoist sage is a superior outlaw who has freed his mind from distinctions, from good and evil, life and death, pleasure and pain. But the Chinese view differs from the Indian in that the sage need not necessarily abandon his worldly duties, for as "king without and

* In the child this naturalness is still embryonic, and is similar in kind but not in quality to the naturalness of a "twice-born" adult who has "become again *as* a child."

† And thus "super-natural" and "meta-physical" in the proper sense of being above nature or *physis* when the word refers primarily to class, as in asking, "Of what *nature* is this?" Similarly, the immaterial is that which escapes the abstract category of matter of meter, and cannot be defined. Occidental conceptions of spirit relate it to the abstract rather than the concrete.

sage within" he can continue in outward observance of the conventions though inwardly free from their compulsions. "If the mind is without wind and waves, everywhere are blue mountains and green trees."[2]

In Chinese and Indian culture the "superior outlaw" was in the social order but not of it in the sense that society itself usually recognized him and even honored him. For the culture admitted the relativity and the limitations of its own conventions, and could assent in theory to the validity of a viewpoint beyond its understanding, as one might extrapolate an outside to a closed space of which one knows only the inside boundaries. But the cultures of the West, both Christian and secular, have never really had a place for the "upper outlaw," a fact which has surprisingly far-reaching and disastrous results. Christian theology has persistently identified the system of conventions—the moral order—not only with the will but also with the very nature of the Absolute, and has been resolutely opposed to any idea of God as beyond good and evil. The secular cultures of the West are in an even worse state, for having abandoned the belief in God there remains absolutely nothing but the system of conventions. Thus the secular state recognizes nothing outside its jurisdiction, nothing that "is not Caesar's." The Church admitted a degree of supra-conventionality in God through the doctrine of his infinite love and forgiveness. Behind the Law stood the Person who made the Law, an understanding heart rather than a blind principle. But the secular state cannot admit anything higher than Law, and thus is ever in danger of becoming a mechanism without mercy.

To identify the system of conventions with the Absolute is to weight them with excessive authority, and is actually a danger to the system, somewhat as an electric wire will burn out when the current is too strong for it. The Western mind seems to have difficulty in thinking in other terms than extremes—true or false, right or wrong—and thus finds it hard to see that a conven-tional principle can be true and important without being absolutely true and absolutely important. Thus when there arise, between the man and the system, the types of conflict described above there is no release save through catastrophic revolt against the whole system. But such revolutions "throw out the baby with the bathwater," and usually establish worse tyrannies than those which they remove, since they go to the opposite extreme, and every extreme is a tyranny.

This Asian parallel suggests, then, that the most important function of a psychotherapy is to deliver people from the inevitable warping and the inevitable violence done to them in the course of their upbringing and education. It is not simply to ease the process of acculturation for intractable individuals, to "adjust them to the group." We must recognize that acculturation is at once a blessing and a curse, that it is both a necessity and a positively splendid achievement which, however, entails the price of damage and danger. But as meat salted for preservation may be unsalted for eating, so the wise society provides a cure for the ill effects of social discipline—an initiation, a therapy, for the fully cultured adult which releases him from compulsive identification with the system of conventions.

One may ask whether Western psychotherapy is in a position to fulfill this function. In some respects it begins to be so, as, for example, in its emphasis on self-acceptance and in its faith in the self-healing properties of the psyche. But its official "schools" seem, as yet, to have a long way to go, and this not only because of the still prevalent notion that its role is to provide adjustment to social norms. The chief difficulty is that the standard systems of psychotherapy—Freudian, Jungian, and Adlerian, as well as the more physiologically oriented systems of "orthodox" psychiatry—are still all too unconscious of their own identification with some of the more basic social conventions. One might say that these systems have an unanalyzed Unconscious whose contents are primarily intellectual, consisting of unexamined assumptions and premises derived from the philosophy and scientific theory of the nineteenth century. These

include those conceptions of time, motion, causality, progress, history, and human nature which appear all too easily to be laws of nature rather than conventions of thought. For many years it has been fashionable to underrate the power of ideas as factors in producing neurosis, and the emphasis has been laid on the traumatic experiences of childhood, a fashion reflecting the theoretical assumption that physiology is more "real" than ideology. But the therapist can no longer neglect the force of ideas, and especially of unconsciously accepted ideas. He must be a philosophical analyst as well as a psychoanalyst—and this he cannot be unless he is himself philosophically "analysed." He must be able to reveal the conflicts arising from the patient's unconscious self-identification with his conventional history, with his identity in time, with his conventionally delineated "body," * and with many other conceptual entities.

Little can be done in this direction unless Western thought can overcome its characteristic fear that the only alternative to the conventional systems is total chaos. Thus many readers of the above may have formed the impression that the real, concrete, and nonconceptual world (corresponding in our analogy to the Rorschach blot) is in fact a dis-order, a lawless and directionless wasteland. But this, again, is but another symptom of unconscious acceptance of a conventional pattern of thought which provides "con" as the only alternative to "pro." Both order and disorder belong to *māyā*, to the category of conceptual projections upon a real world which altogether escapes the dualistic definitions of our thinking. Thus the one indispensable prerequisite for a therapy of this kind is the realization that man's concrete identity can *never* be an object of formal knowledge, definition, and control. This realization forces him into a psychological trap where nature—in her kindness—virtually compels him to see that he has no other alternative than a leap into the dark. And this is that "leap of faith" which is essential to every creative action: not belief in a formally defined God or philosophical dogma, but trust in that most concrete unknown which is the *atman*, the actual self.

* Since it is really a matter of opinion that I am "this" body as distinct from, e.g., a group of bodies (family or community), or that I am effectively confined within my skin.

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LIFE HISTORY AS THERAPY

PART II

ON BEING AWARE

HAROLD KELMAN

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AWARENESS, or being aware, is a crucial notion in my thinking and one on which there is an extensive literature, particularly in the East. However, I will quote mainly from Krishnamurti, a Hindu educated in the West, and Watts, an American Orientalist.

To them, L. L. Whyte may help us to make the transition. "Unitary thought rejects the dualistic implication of the conception of consciousness, and suggests that the valuable element in it is the reference to a relation of attention between the organism and a particular external or internal stimulus. . . . Attention to it ('a stimulus') is always transient. Nothing ever remains continuously in consciousness. . . . It is therefore wrong to isolate those transient moments of attention to particular forms, to endow them with a special metaphysical status as a 'state of consciousness' and then to ascribe to consciousness the supreme directing role in behavior. . . . Attention is an essential prior condition to adaptation to any novel stimulus. . . . Attention is only a transitory focusing of the extended system of processes which guide behavior. It is an inherent weakness of subjective thought that it must misconceive and exaggerate the role of attention."[49] Whyte indicates how unitary thought can help us transcend spurious dualisms in general, and specifically in the notion of consciousness (consciousness-unconsciousness) to which a permanent status is attributed, functioning as though it held a directive capacity. He narrows our focus to attention, which is transitory. And I add that the process of attending is but one aspect of being aware.

I shall start my comments on awareness with Krishnamurti because Watts follows him closely. "The word 'awareness' is used in the sense given it by J. Krishnamurti, whose writings discuss this theme with extraordinary perception."[50] Some comments about their styles of writing which manifest their philosophical premises are essential. Both use "metaphysical language" which "is negative because it is trying to say that words and ideas do not explain reality."[50] "But we must remember that 'metaphysic' in this sense is not speculative philosophy. It is not an attempt to anticipate science and give a logical description of the universe and its origins. It

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Harold Kelman, M.D., Harvard, 1931, D.Md.Sc., Columbia, 1938, is a diplomate of the American Board of Neurology and Psychiatry, and a fellow of the American Psychiatric Association. He is editor of *The American Journal of Psychoanalysis*, Dean of the American Institute for Psychoanalysis, and a lecturer there and at the New School for Social Research. This paper was read before the Association for the Advancement of Psychoanalysis at an Interval Meeting on October 16, 1955.

is a way of representing a knowledge of the present. Religious symbols are especially characteristic of Christianity, Islamism and Judaism, whereas doctrines of the Oriental type are metaphysical."[51]

Both Krishnamurti and Watts keep repeating what this or that is not. They both keep posing questions, and Krishnamurti often uses the rhetorical 'is it not'? The style of both is conversational, with freuent use of the first person singular. Rarely do they use we—one, or people, in an impersonal sense. You constantly feel they are talking directly, specifically to you, hearing your responses, as answers and questions and attempting to clarify them.

They do not use the method of definition of the West but keep returning to the same topic, each time pointing at more and more aspects and nuances. They guide you by pointing at, and by clearly indicating that you must go the way yourself to feel what they mean, because again and again they assert that reality cannot be put in words, but must be felt by each individual being the moment. They both use the intuitive method of the East—i.e., the method of pointing at and indirection. They both use a language that harmonizes the intuitive of the East and the theoretic of the West. Both are out to help individuals become aware of what is and be the moment and thereby transcend the dualisms in us all and in our environment. They both put responsibility squarely on the individual because they assert that as each person becomes more aware he will help others become aware, and thereby society—which is people—will find "inspired spontaneity" (Watts) and "creative reality" (Krishnamurti) more available to it.

Krishnamurti asks: "How is one to be aware? That is our problem. How is one to have that awareness—if I may use this word without making it mean specialization?" He says being specialist-minded—looking to specialists or being specialists, such as a doctor or lawyer—makes us want to develop a capacity or a technique for unraveling our problems and all this stands in the way of being aware.

"How is one to be capable of meeting life as a whole? . . . To know ourselves means to know your relationship with the world—not only with the world of ideas and people, but also with nature, with the things we possess. That is our life—life being relationship to the whole.

"How is one to be aware? . . . First we are aware, are we not, of a response to a stimulus, which is an obvious fact; I see the trees, and there is a response, then sensation, contact, identification and desire. . . . Watch yourself without any identification, without any comparison, without any condemnation; just watch, and you will see an extraordinary thing taking place. You not only put an end to an activity which is unconscious—because most of our activities are unconscious, you not only bring that to an end, but, further, you are aware of the motives of that action, without inquiry, without digging into it. . . . Experiment with this and you will see for yourself. Just be aware—without any sense of justification—which may appear rather negative but is not negative. On the contrary, it has the quality of passivity which is direct action. . . . After all, if you want to understand something, you have to be in a passive mood, do you not? You cannot keep on thinking about it, speculating about it or questioning it. You have to be sensitive enough to receive the content of it.

"Is intelligence a matter of specialization?—intelligence being the total awareness of our process. . . . To realize the highest forms of intelligence—which is truth, which is God, which cannot be described—to realize that we think we have to make ourselves specialists. . . . To understand a problem obviously requires a certain intelligence and that intelligence cannot be derived from or cultivated through specialization. It comes into being only when we are passively aware of the whole process of our consciousness, which is to be aware of ourselves without choice, without choosing what is right and what is wrong. When we are passively aware, you will see that out of that passivity—which is not idleness, which is not sleep, but extreme alertness—the problem has quite a different significance. . . . Most of us are

incapable of being passively aware, letting the problem tell the story without our interpreting it. . . . We want a result from the problem, we want an answer, we are looking to an end; or we try to translate the problem according to our pleasure or pain; or we have an answer already on how to deal with the problem. . . . This passivity is not a question of determination, of will, of discipline; to be aware that we are not passive is the beginning. To be aware that we want a particular answer to a particular problem—surely that is the beginning. . . . Then as we begin to know ourselves in relationship to the problem—how we respond, what are our various prejudices, demands, pursuits in meeting that problem—this awareness will reveal the process of our thinking, of our inward nature. And in that there is a release.

"What is important surely, is to be aware, without choice, because choice brings about conflict. The chooser is in confusion, therefore he chooses. . . . The man who is clear and simple does not choose; what is, is. . . . The important thing, therefore, is to be aware from moment to moment without accumulating the experience which awareness brings; because the moment you accumulate, you are aware only according to that accumulation. . . . That is, your awareness is conditioned by your accumulation and therefore there is no longer observation but merely translation. Where there is translation, there is choice, and choice creates conflict; in conflict there is no understanding.

"Life is a matter of relationship; and to understand that relationship, which is not static, there must be an awareness which is pliable, an awareness, which is alertly passive, not aggressively active. . . . We shall see, as we go into it more deeply, that we begin to dream, that we begin to throw up all kinds of symbols which we translate as dreams. Thus we open the door into the hidden, which becomes the known; but to find the unknown, we must go beyond that door—surely, that is our difficulty. Reality is not a thing which is knowable by the mind, because the mind is the result of the known, of the past. Therefore the mind must understand itself and its functioning, its truth, and only then is it possible for the unknown to *be*."[52]

With certain of the above ideas we are familiar—the emphasis on relationship, holism, and the importance and extent of unconscious processes and the notion of stimulus-response. We are aware in therapy how patients impatiently need to have answers and solutions even before they know what the problem is, and how they search for techniques and methods to use as magic keys to get answers. I have emphasized the notion of process and attempted to expose static notions in theory and in our thinking in general in the West.[40] I have also pointed out how we attempt to make of reality a thing, and that words are about—what we feel but are not feeling. What he says about symbols and dreams are close to my own ideas on these two subjects. His definition of "intelligence being the total awareness of our process" is the most penetrating I have come upon.

The concept most difficult to feel—not to grasp because it is not graspable and not to know because it is not knowable—is that of alert, passive, choiceless awareness. Our notions of action and reason in the West interfere with our feeling and being aware. Gandhi's belief in *ahimsa* (nonviolence) manifested in the *satyagraha* (*satya*-truth, *graha*-firmness) movement—passive, nonviolent resistance—was a major factor in gaining Indian independence. Indeed, this was a potent, concrete example of the strength and intensive activity in the Eastern notion of passivity.

What Krishnamurti says further in his Chapter 8, "On Awareness," may help a bit more, but it is only by being open to and experimenting with being aware that this process can come to have meaning for you. This I have found, and that feeling being aware has been very helpful to me in what we refer to as self-analysis. In this chapter Krishnamurti points out the difference between introspection and awareness, and in other places he shows the limitations of meditation, prayer, and the submission to or domination by a teacher, a guru, a God, a dogma, or any system of ideas.

"Where there is introspection, which is the desire to modify or change the responses, the reactions of the self, there is always an end in view; when that end is not achieved, there is moodiness, depression. . . . Introspection is a process in which there is no release because it is a process of transforming what *is* into something which is not. . . . In that action, there is always an accumulative process, the 'I' examining something in order to change it, so there is always dualistic conflict and therefore a process of frustration.

"Awareness is entirely different. . . . There is no end in view but awareness of everything as it arises. . . . Introspection is self-improvement and therefore introspection is self-centeredness. Awareness is not self-improvement. On the contrary, it is the ending of the self, of the 'I', with all its peculiar idiosyncracies, memories, demands and pursuits. . . . The man who wants to improve himself can never be aware because improvement implies condemnation and the achievement of a result. Whereas in awareness there is observation without condemnation, without denial or acceptance. That awareness begins with outward things. . . . This awareness, being sensitive to things, to nature, to people, to ideas, is not made up of separate processes, but one unitary process. It is a constant observation of everything, of every thought and feeling and action as they arise within onself. . . . Awareness is from moment to moment and therefore it cannot be practiced. When you practice a thing, it becomes a habit and awareness is not habit. A mind that is habitual is insensitive, a mind that is functioning within the groove of a particular action is dull, unpliable, whereas awareness demands constant pliability, alertness.

"Thus there is a vast difference between awareness and the self-expansive improvement of introspection. Introspection leads to frustration, to further and greater conflict, whereas awareness is a process of release from the action of the self. . . . As there is more and more expansive awareness, there is greater and greater freedom from all the hidden movements of thoughts, motives and pursuits. Awareness is freedom, it brings freedom, it yields freedom, whereas introspection cultivates conflict, the process of self-enclosure: therefore, there is always frustration and fear in it."[53]

Someone asked Krishnamurti: "Who is aware?"

"When you are angry, at the split second of anger or of jealousy or of joy, are you aware that you are joyous or that you are angry? It is only when the experience is over that there is the experiencer and the experienced. . . . At the moment of experience, there is neither the observer nor the observed: there is only experiencing. . . . Who is it that is aware? Surely such a question is a wrong question, is it not? . . . A man who does not demand anything, who is not seeking an end, who is not searching out a result with all its implications, such a man is in a state of constant experiencing. Everything then has a movement, a meaning; nothing is old, nothing is charred, nothing is repetitive, because what *is* is never old. The challenge is always new.

"Introspection leads to frustration, to further conflict, for in it is implied the desire for change and change is merely modified continuity. . . . Awareness is a state in which truth can come into being, the truth of what is, the simple truth of daily existence. . . . You must begin near to go far but most of us want to jump, to begin far without understanding what is close. As we understand the near, we shall find the distance between the near and the far is not. There is no distance—the beginning and the end are one."[54]

In this chapter Krishnamurti continues to develop what being aware is by pointing to what it is and what it is not, and by showing that being aware is a unitary process. He indicates how being aware frees us from inner dividedness, conflict, choosing and confusion and from the action of the self. As long as we are not being aware, experiencing, we feel there is an I, a self, an experiencer and an experienced—the object of experience, an observer and *an* observed. That Horney was moving in this direction is indicated when she says that increasing awareness can help us outgrow

the "dark idolatry of self" (Shelley), meaning being dictated by an Idealized Image. Although I feel she meant something similar to Krishnamurti's creative reality by her concept of the real self, I feel the term "real self" was not a happy choice because it uses the notion "self," and the term "the real self" lends itself to being misconstrued as a thing, a something, which it is not, and as having a specific location somewhere in us. It also can be misunderstood to mean that it is a dormant something to be awakened, when spontaneity is always alive in us.

In her statement "Self-knowledge ("ever-increasing awareness") then, is not an aim in itself, but a means of liberating the forces of spontaneous growth"[29] I feel she goes part of the way. As I understand Krishnamurti, being aware is means and ends: means as ends and ends as means, and with that I would agree. This also connects with his statements that "we must begin near to go far", "distance between the near and far is not" and "there is no distance—the beginning and the end are one." That there has to be a beginning and an ending, that they are somehow separated somethings is a Western notion. The Freudian dualistic notion of past and present being two separate locations in time and space is an expression of such thinking. Gestaltists come close to the idea of beginning and ending as one when they say life is an extended gestalt, extending from here and now into the past and into the future and being all one. I have stated the only time and place we can ever be is here and now. Being aware is being the moment; it is the what and how, here and now. Later I shall show that all we can ever have to deal with is the present, present feelings, thoughts, willings and actions. Present feelings may be clothed in symbols referring to the past, present or future but the feelings are of the immediate moment. Also I shall show that including, excluding, overemphasizing, underemphasizing past or present are pseudo-problems.

Feeling the present, the here and now, in the sense of being the present, the moment, is accurately communicated and poetically expressed in this woman's associations. They are from an hour in which she had brought up, and was helped to feel into, what time meant to her. Much of the material from this session is omitted, as well as the analyst's comments. His attitude was implicitly interpretative by encouraging her to go on with what she was bringing up. He did so by using her exact words and asking her, e.g., "What more about testing each moment of the present?" And, "What further about feeling the flow of time?"

"I have the feeling that I'd like not to have time slip by. I want to be conscious of every minute, even if I don't do anything. I used to let time, *the present,* fritter away and now I'm reluctant to do that. I have a sharper feeling about time, so when I'm apt to fuss about something I remind myself I'm wasting time in the sense that I'm not enjoying time. Time won't be repeated, so it's very important to *taste each moment of the present,* at least be conscious of time —and this is new for me. In the past I've stumbled through time, like some people have no sense for money.

"I don't have a desire to live feverishly or anything like that. I have the feeling I want to make time count. I'm trying somehow to convey the idea I've been wasting time *of the present* and now I want to be economical of time, in the sense of *fully realizing each moment*—whatever I do—reading, walking, anything—of getting the most out of each moment. And it occurs to me now that it gives me a new slant on how others have lived. The effect of feeling this way is it seems to *myself a little less hurried*—I mean *inwardly.* I've always been in a breathless state as if to push through time. Time seemed something for me to live out, whereas now I feel—*of itself time has value*—that an hour is not something to live through to jump over, but to *live in*—to *relax in.*"

"Originally it was a habit with me, when life was difficult for me and intolerable, what made it tolerable was to leap through. But now it is as if I ask myself why am I rushing through this hour and what is there about the next hour or the next year that

I want to go through this one? Oh, dear, I'm having lots of trouble. *To me it never seemed that the present was worth taking any trouble with.* I mean in the sense of acknowledging that it exists for one thing rather than looking over it into the future or in the past. I have nothing in mind I want to do. I don't mean kick over the traces or be reckless. I don't mean make up for lost time. I want more to *feel the flow of time.* I no longer believe in the future in the sense of when I'm going to do everything, i.e., the future which I preferred to the present. It was an excuse for postponement. I've had the feeling of late that I wanted to stop certain readings and do others, and not overdo certain things with my work. I have a desire to read more—do *leisurely* reading which I haven't done in years—because its more enjoyable to me *even though it hasn't any other aim* but the enjoyment I get from it. That's just one path it has taken. I think, it's *living more concretely in the present* from what I feel." •

Krishnamurti's statements that introspection leads to expansive self-improvement, that awareness is not improvement but a process of release from the action of the self, and that more and more expansive awareness leads to greater freedom, bear some further comment. At first glance the statement that awareness is not improvement sounds startling, but only so long as we are caught in the dualism of an "I" observing a "me." As long as this obtains there will be a self that is comparing and thinking in terms of proving and improving. Awareness transcends these dualisms. Then there is neither proving nor improving; there is only being aware and creative reality. The spontaneous energies in being real are always active in us.

Krishnamurti also speaks of expansive self-improvement and expansive awareness. Put in our terms there is expanding of neurotic processes and healthy growing. Earlier I asserted that all natural processes are phasic and that the forms of these phases are contracting and expanding. For this and other reasons I feel it is more accurate to speak of boundaries as contracting and expanding boundaries of being aware, as a rhythmic, phasic process having direction toward greater dualism or greater wholeness. I feel this way is more accurate than speaking of possibilities and limitations, which are expressions of dualistic thinking. My boundaries of being aware are the present form of my functioning, the what and how of my here and now. Boundaries of awareness can be contracted and expanded to the ultimate of human and of individual possibilities and limitations. But in this sense and from moment to moment my possibilities are my limitations. They are synonymous. Duality becomes one. Because of their dualistic origin the word "possibilities" has acquired the sense of expanding as a separate entity or process, and "limitations" the sense of contracting as a separate entity or process.

I indicated above that the most difficult concept to feel is being aware and yet this might be decreasingly so to the extent we have had more experience in free associating in analytic therapy. Not as a detailed set of instructions at the beginning of therapy, but in the course of therapy, we convey to a patient that he tell us everything that comes into his mind without reservation or choice, no matter how trivial or unpleasant it might be to him. I specifically said "comes into his mind" to expose the problem that suggestion creates. Unwittingly, the therapist has directed his patient to mental processes. It is essential to convey to a patient the values of observing and reporting all that comes up and goes on in him, which includes not only thoughts but feelings, impulses, bodily sensations; to be as open as he can to all aspects of his being. As he proceeds in analysis through our interpretations, in the form of questions, explanations, descriptions, and the sounds we make, we encourage his alertness to areas just emerging into awareness. More and more, he becomes more open to his whole being. In time his mind no longer acts as a distracting influence and he comes to know the constructive value of silence, of being quiet and being still. Then aware-

• Personal communication from psychoanalytic practice of A. E. Koblentz, M.D.

of greater depths in his being become available to him. He becomes humble before the natural, spontaneous, creative energies in him. As he reaches and passes such a point in his growing he will more frequently and for longer periods feel being aware, being the moment and being one with the all in the immediate present. What I have just described is quite similar to the process of becoming passively alert and choicelessly aware, as Krishnamurti has indicated.

In view of our assumption of real selfness, creative reality, or inspired spontaneity, I feel it important to draw attention to certain comments made by therapists about or to patients, such as: "You are not free associating." Or, "After several years the patient really began to free associate." Or, "You have not been free associating because you have not brought up much childhood material or anything about the age of seven."

Such statements imply that free associating is a concrete, specific thing or a state. I would say that patients are always associating when they are talking, and often when they are not, because who can anyone talk, think or feel about but about himself, even as he is talking, thinking or feeling about somebody else, an object or the weather? The question is not is he free associating, but how freely is he associating? And is his associating becoming freer and freer? Thinking in terms of free associating or not is an expression of dualistic thinking when associating is a question of degree. Explicit or implied comments such as the above are usually responded to by a patient as threats and block freer associating. It is the analyst's task to discover the blocks to freer associating and help his patient work them through.

Dualistic, and hence dogmatic, attitudes in the therapist, such as those above, come from an overemphasis on mental processes and talking, from a lack of feeling for holism, and an unawareness of the constructive values of silence, "creative quietism" (Lao-tzu), and stillness. Such a therapist does not have a sufficient feeling for the vastness of nonverbal communicating and communing, or of himself as an aspect of the analytic process which is a single, integral reality.

Watts opens his Chapter 5, "On Being Aware," with: "The question, 'What shall we do about it?' is only asked by those who do not understand the problem. If a problem can be solved at all, to understand it and to know what to do about it are the same thing. . . . We do not need action—yet. We need more light. Light, here, means awareness—to be aware of life, of experience as it is at this moment, without any judgments or ideas about it. In other words, you have to see and feel what you are experiencing as it *is*, and not as it is named. . . . Because awareness is a view of reality free from ideas and judgments, it is clearly impossible to define and write down what it reveals. Anything which can be described is an idea, and I cannot make a positive statement about something—the real world—which is not an idea. I shall have to be content with talking about the false impressions which awareness removes, rather than the truth which it reveals. . . . Therefore most of what follows will have to have a rather negative quality.

"How are we to find security and peace of mind in a world whose very nature is insecurity, impermanence and increasing change. . . . It must be obvious, from the start, that there is a contradiction in wanting to be perfectly secure in a universe whose very nature is momentariness and fluidity. . . . To put it more plainly: the desire for security and the feeling of insecurity are the same thing. . . . We look for this security by fortifying and enclosing ourselves in innumerable ways. . . . I can only think seriously of trying to live up to an idea, to improve myself, if I am split in two pieces. There must be a good 'I' who is going to improve the bad 'me,' and the tussel between the two will very much stress the difference between them. Consequently 'I' will feel more separate than ever, and so merely increase the lonely and cut-off feelings which make 'me' behave so badly.

"The principal thing is to understand that there is no safety or security. . . . To

stand face to face with insecurity is still not to understand it. To understand it, you must not face it but be it. . . . The notion of security is based on the feeling that there is something within us which is permanent. . . . We are struggling to make sure of the permanence, continuity, and safety of this enduring core, this center and soul of our being which we call 'I'. . . . We do not actually understand that there is no security until we realize that this 'I' does not exist.

"Understanding comes through awareness. . . . You may ask, 'Which experiences, which sensations and feelings, shall we look at?'. . . . I will answer, 'Which can you look at? . . . The answer is that you must look at the ones you have now. . . . There is no experience, but present experience. What you know, what you are actually aware of, is just what is happening at this moment, and no more.

"But what about memories? . . . From memories you infer that there have been past events. But you are not aware of any past events. You know the past only in the present and as part of the present. We are seeing, then, that our experience is altogether momentary. . . . To say that experience is momentary is really to say that experience and the present moment are the same thing. To say that this moment is always dying, or becoming past, and always being born, or coming out of the unknown, is to say the same thing of experience. The experience you have just had has vanished irretrievably, and all that remains of it is a sort of wake or track in the present, which we call memory. While you can make a guess as to what experience is coming next, in actual fact you do not know. Anything might happen.

"While you are watching this present experience, are you aware of *someone* watching it? . . . Never at any time were you able to separate yourself from your present thought, or your present experience. . . . You were never aware of being aware. . . . The notion of a separate thinker of an 'I' distinct from experience, comes from memory and from the rapidity with which thought changes. . . . If you imagine that memory is direct knowledge of the past rather than a present experience, you get the illusion of knowing the past and the present at the same time. This suggests that there is something in you distinct from both the past and the present experiences (an 'I' which is something constant and apart).

"But as a matter of fact, you cannot compare this present experience with a past experience. You can only compare it with a memory of the past, *which is a part of present experience.* When you see clearly that memory is a form of present experience, it will be obvious that trying to separate yourself from this experience is as impossible as trying to make your teeth bite themselves. There is simply experience. . . . There are no feelings but present feelings, and whatever feeling is present is 'I'. . . . We are being aware of the fact that any separate 'I' who thinks thoughts and experiences is an illusion. To understand this is to realize that life is entirely momentary, that there is neither permanence nor security, and that there is no 'I' which can be protected.

"Sanity, wholeness, and integration lie in the realization that we are not divided, that man and his present experience, are one, and that no separate 'I' or mind can be found. . . . To understand this moment I must not try to be divided from it; I must be aware of it with my whole being. This, like refraining from holding my breath for ten minutes, is not something I should do. In reality, it is the only thing I can do. Everything else is the insanity of attempting the impossible."[55]

Watts points to being aware by what it is not and what it is. Reality, he says, is indefinable because it is the reality in which man lives and should not be confused with the reality, the universe which science describes. "Science is talking about a symbol of the real universe."[56] But when the symbol is taken to be what it describes, what it stands for, all manner of problems increase. And the symbols "I" and "me," which are creations of our mind, when taken to mean a something constant and unchanging, separate us from reality, create and perpetuate

our dividedness. But by being aware, being the moment, being experience, the pain and insecurity we have been struggling against are absorbed. "It is as hard to describe how this absorption works as to explain the beating of one's heart. The 'open' mind does this as most of us breathe: without being able to explain it at all. The principle of the thing is clearly something like *judo*, the gentle (*ju*) way (*do*) of mastering an opposing force by giving in to it."[37]

What he has to say about memory and past in present is crucial for this paper. From memories we infer that there have been past events, emphasis on inferring, which is a logical, conceptual process. We know the past only in the present and as part of the present. It is startling how the self-evidence of this fact has been missed, that we can only know what we know now, and that this knowing is about the past, the present and future. When we are the moment we are not knowing about, we are being the moment. Watts' definition of memory is beautiful in its simplicity: "It is a sort of wake or track" in the present of an experience. The problem of memory has been inflated and confused by connecting it with mind. We do not remember with our minds; we remember, to use that word momentarily, with our whole being. Put otherwise, memory is the effect on us totally of each life experience, which modifies the effects of all preceding experiences up to that moment. That is how come I say totally we are our memory, totally we are our life history. Therefore, our total being, our memory, our life history are synonymous and this is one reason how come I speak of life history as therapy and not in therapy. Other reasons for speaking of life history as therapy I shall bring up later. I agree with Watts that memory is a form of present experience and, as I shall later show, being the moment, when expressed in verbal symbols will select those symbols which appropriately convey the moment. Those symbols can be selected from that individual's total life experience up to and including that moment.

Up to this point, I have written this paper in the style and form which I have for a number of reasons. I have used quotes extensively not only to present exactly what others have said but, more importantly, to convey the flavor of the person's writing. The how and what a person says are inextricably one. They convey the spirit of the person, his implied and explicit assumptions, his philosophical premises and the detailed expressions of all these, whatever topic he is discussing.

The paper has had this style and form to convey the development of the ideas of Horney, Martin and Ivimey, as well as of my own and to function as background for the subject of this paper. In a way, the paper is an historical survey of psychoanalysis from the vantage point of one topic. Naturally, many other contributors to this subject have not been mentioned. What I also wanted to show was that each contributor was a product of his time, of his area of interest, and the area of the world in which he was brought up or which significantly influenced him. Subsequent work could not have been done without the previous efforts of many. Also this discussion shows there are no final answers and that there are many ways of attempting to help human beings understand and be themselves. My ideas presented here I regard as a step in a direction. Their invalidation by subsequent work will be their validation. For in being aware, the challenge is always new. What comes into awareness is the unknown which is always new. The known is always old.

To develop my main thesis it will be necessary to repeat and refer back to previous comments of my own and others. The only place we can ever be is here and the only time we can ever know is now. Here and now are allwhere and anywhen. Being aware is what and how, here and now. We can only be the moment, the immediate present, the present experience. The only feelings, thoughts, willings, actions we can be are present ones. We cannot have, for example, past feelings here and now. We can only have memories of past feelings in the immediate present. The notion that, for example, the feeling of anger I have now toward my father is the

same as, is identical with, the feeling when he spanked me when I was four is only possible in static, dualistic thinking.

In spite of an ancient heritage of process thinking (Heraclitus and Eastern philosophers) and modern advances in process thinking (L. L. Whyte, Angyal) much thinking is governed by Aristotelian static, dualistic thinking. The error regularly made, as long as we are governed by notions of permanence, is that what feels like, is similar to, akin to, equivalent to, associated with, as if it were, that reminds me of, erroneously will be believed to be identical with what happened in the past. In process thinking an identical repetition of a past feeling is an impossibility. You cannot step into the same stream twice.

You cannot be aware of past events in the present. You can only infer that there have been such-and-such past events. An inference is a logical conceptual process. As a result of your deductions you will have a knowledge about such possible past events. You will be functioning like a scientist who has knowledge about reality, an explanation, a description of reality, but you must feel reality in the immediate present to "know" it in the sense of "be" it. Even if you have a number of eye-witnesses to that previous event you still will not be aware of it, although the probability of its having occurred approaches certitude. All you would be doing is verifying that such an event had occurred. But the fact of a past event is quite a different matter from the awareness of that past event now.

You cannot compare a present awareness, present feelings, with past feelings. You can only compare your present feeling with a memory of that past experience. As Watts said, memory is a wake, a track of a past experience in the present. Goldstein in his book, *Human Nature,* has said something similar.[58] I mentioned above that the subject of memory has been complicated by inflating its importance and connecting it with mind. This confusion has been added to by consideration of memory as an isolated capacity and a thing, and by the notion that after an event a photographic impression somehow is imprinted on our brain cells where it remains dormant, to be called upon as is at the appropriate moment. Totally we are the effects of all our life experiences up to and including the moment. In each event the whole of us participates more and less. The whole of us participates and is affected, therefore all of us remembers. We remember with our totality, and our whole being at every moment is our life history, is our memory. Life history in this sense is not information about, or facts with reference to, but our past as our present, not our past in our present. Our past is our present. They are one.

When our thinking is genetic, mechanistic and dualistic a number of pseudo-problems are created. Dictated by static notions of permanence and entities, past and present are unwittingly conceived of as separate entities residing in specific locations. With such thinking goes the notion of a constant, permanent "I" outside of experience that observes and remembers and stores up these memories in layers, with the oldest ones on the bottom. Consonant with such thinking, therapy is similar to an archaeological excavation and if memories from the deepest layers are not brought up, the therapy is considered superficial—a criticism frequently made of Horney. Understandably, in such a therapy tracing present symptom formation and personal relational constellations to their origins is of crucial import.

Such thinking leads to the erroneous notion that if one could leap to the past, which is as possible, literally and figuratively as jumping out of your skin, and there pinpoint and tear up by the roots the causes of later neurotic development, much time would be saved. As I shall show, it is first an impossibility; second, it is based on causal thinking and fallacious, point-for-point correlations; third, it is based on an overemphasis on technique, and fourth, assumes the patient as a passive object manipulatable by an all-knowing therapist. Such thinking naturally encourages the unearthing of the past and childhood by manipulating the patient and his environment and by the use of narcosynthesis, hypnoanalysis and drugs.

Implied is another notion: that the more information we have about a patient, or that he is confronted with, the quicker and more effective the therapy will be. In my experience I have rarely felt I lacked information. More important was how I could help my patient become meaningfully integrated with what he had already fulsomely told me. Then information about himself could become real knowledge of himself.

In process thinking, notions of permanence, entities and genetic mechanistic dualisms have no place. Organism-environment is considered a unitary process from the moment of impregnation through life. It, living, takes place in a four-dimensional, space-time continuum. The organism develops, evolves, unfolds according to its nature, as circumstances permit. Rhythmicity and phasic activity are characteristic of the organism throughout life, as a whole and in its part processes. In its evolution, integrating, which is the pattern of living, is at first relatively global and undifferentiated. We see such responses in infants and in adults with severe brain injuries or high spinal cord lesions. As life proceeds, and as a second phase of any new learning experience, we see differentiation of parts of the organism with relative autonomy. In infants it takes time for temperature, respiratory and cardiac regulation to establish themselves. Later come locomotion in the erect position, bowel and bladder control, and then speech. As a third phase we have unified action of the whole organism based on interdependence of parts. What I have just described is what Martin has emphasized, namely that integration precedes individuation—the differentiation of parts. He does not mention my third phase but clearly implies it when he says that with total awareness of conflict acquired conflicts are resolved. Then there can be unified action of the whole organism based on healthy interdependence of parts.

In moving through its life cycle, every organism is transformed by each experience, and more significantly at certain crucial phases which are part of the natural rhythm of living. They are birth, infancy, early childhood, later childhood, puberty, early and later adolescence, youth, early and later adulthood, the climacteric, old age and senesence. In women awareness of rhythmicity is more poignant with the menstrual cycle, the nine-month cycle of pregnancy, and the menopause. Rhythmicity and phasic activity are a natural biological phenomenon not only in humans but in the whole animal scale. As general examples of rhythmicity in nature we need but mention the diurnal cycle, the monthly cycle of the moon, the seasons, and the life cycle of plants. Since the pattern of living is integrating from moment to moment, the organism as a whole and in its part processes, more and less goes through phases of disintegration and reintegration, whether the direction is toward greater health or greater sickness. In each moment in living the organism participates as a whole.

Although certain aspects may be foreground, the background also participates. Modification, transformation and change characterize organismal integrating. For an understanding of rhythmically integrating wholes, dualistic and static thinking, the notions of permanence, of entities, of static layers of static persistence of isolated memories, and static residual stages of libido development, are all inadequate.

To be continued

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BOOK REVIEWS

EXISTENCE AND THERAPY: AN INTRODUCTION TO PHENOMENOLOGICAL PSYCHOLOGY AND EXISTENTIAL ANALYSIS. Ulrich Sonneman. 392 pp. Grune & Stratton. New York. 1954. $7.75.

The growing popularity of phenonenological psychology in Europe, and of its application in psychotherapy, behooves us here to familiarize ourselves with it more than we have been doing. This book, the first presentation of its basic principles in English, is intended to fill that need. This psychotherapy (*daseinsanalyse,* existential analysis) derives from the philosophy of existence of Kierkegaard, Husserl, Heidegger and Sartre (although the latter is repudiated as a deviationist), and the psychopathology of Jaspers, Binswanger, Boss, Kuhn and their schools.

About one third of the book is devoted to an exposition of the variations in the concepts of these thinkers as they have developed historically. A second third is intended to disprove or point up the inadequacies of current psychologies: psychoanalysis (Freud, Adler, Jung, Fromm, Horney) and gestalt psychology. The final third is devoted to the application of phenomenological ideas to therapy. Most of the questions preoccupying every therapist are touched upon: dreams, patient-analyst relationship, goals of therapy, diagnosis, the nature of neurosis and psychosis, etc. There is a detailed discussion of one patient in therapy with the author, and of three published cases of Binswanger.

According to this theory, the fundamental error of all modern psychology is the objectification of the self, or the making of an artificial schism between the self as subject (the cognitive, observing analyzing self) and the self as object (the observed, the immediate, the directly experiencing self). This duality must be replaced by the individual's precognitive *being,* which is the basic, irreducible empiric datum of psychic existence.

Practically, being exists in three aspects: being-body (allosomatic), being-with (with one's own personality and with others), and being-in (relationship between the self and the world). Being is characterized firstly by pre-given phenomenological tendencies (psychic drives, needs, conflicts and other such qualities are not things a person has, but states of being, each of which he is). Secondly, by authentic *Truth,* or the idea of the world as it is phenomenally, immediately experienced, rather than the self-alienated, delusional world of cognition, the "Wahn." Thirdly, by its *transcendence* over the object self, over knowledge, over known experience, over external objects, over the world. There can be no continuity between any being-state and an antecedent one; we can only exist in the here and now.

Consequent to this notion, the therapist must discard such concepts as genetic causality in a temporal, historical sense; psychic process; fixed symbolization; spatial or temporal order of experience; culture influencing personality; character typology; and the use of logic and reasoning in analytic interpretations.

Phenomenological therapy addresses itself to the "core, the essential unity maintaining itself behind the neurotic self-dissension that arises from his reflection of himself as his own ego." It is directed toward "the challenging of this true self to come out of its concealment," in other words, to participate experientially to the fullest in the world and stretch toward the future. Limited horizons of knowing and feeling (restrictions) must be broken through, to be replaced by the unlimited phenomenal ho-

rizon, the "be-as-you-are" and "ultimate knowledge."

No theoretical, technical formula can be given to the therapist; he must make a "frontal engagement" with the experience and identity of the patient, rather than seeing the relationship as a situation. Resistances and defenses need not be treated, indeed they cannot arise, since associations are not considered in terms of their unconscious motivations, but only for the nature and truth of their content. The most productive communication from the patient does not consist of any deliberative presentation—intellectual ideas must become lived ideas—but rather of his spirit and attitudinal mannerisms (preverbal). Instead of using the logical interpretations classical of psychonalysis, the *daseins*-analyst works by "setting attitudinal examples." The therapist's attention must be constantly oriented toward experience contents. There is neither an authoritative role, nor a nondirectiveness; neither judgmental nor logical interpretation. However, in practice adjunctive measures may be employed, such an environmental manipulation, directive counseling, even the prescription of "rhythmization" exercises, provided these contribute toward the ultimate freedom to be-in-the-world with an absolute openness.

For this reviewer, the book contained many fresh and stimulating ideas, but these have to be gleaned from a most difficult and overabundant verbiage. Their value is lessened by the complex terminology—apparently inherent in existentialist philosophizing—and by the complicated sentence structure, characteristic to the author's native Germanic idiom.

Many concepts, although couched in different words, are familiar to the Horney therapist: the focus on the holistic being, the notion of real self as compared with neurotic or idealized self, the entire concept of self-alienation, our attempt in therapy to bring the intellectual into the realm of inner experience, our appeal to spontaneity and emphasis on freedom from compulsive restrictions, the opening up to and facing one's anxiety and inner activity, and others. This reader feels that a further comparative study of these two theories could be most productive, and could offer a possible new dimension to our therapy. As important as awareness of the "why" and "how" of an inner experience is the "what"—not only the categorial "what," whether he is experiencing joy or sadness or anger, but also the phenomenal "what," the precise nature of his joy or anger.

This book is a most serious and noteworthy attempt to present an extremely difficult subject, which must be at once simple enough to reach a psychiatric audience unacquainted with it and in a language alien to that in which it has originated. As commendable as it is, this reviewer feels it is not the final or definitive work. A clearer and simpler presentation is needed for a more rewarding reading experience, and a more adequate understanding of it by the American psychotherapist.

—JACK L. RUBINS, M.D.

THE INITIAL INTERVIEW IN PSYCHIATRIC PRACTICE. By M. Gill, M.D., R. Newman, M.D., F. C. Redlich, M.D., with the collaboration of M. Sommers, M.D. 423 pp. International Universities Press, Inc., 1954. $6.

In presenting for the first time transcripts and phonograph records of three initial interviews conducted at the Psychiatric Dispensary of the Yale University School of Medicine, as well as a survey of pertinent literature on interviewing, Drs. M. Gill, R. Newman, and F. C. Redlich, in collaboration with Dr. M. Sommers, have rendered psychiatrists and persons in related fields a great service.

The traditional approach of the doctor to his patient, as taught in medical school, has consisted of history taking, examination, diagnosis and treatment. The psychiatric interview followed this pattern with the anamnesis from the family, the mental status of the patient, the selection of the most pertinent diagnosis from the standard nomenclature, and the recommendations of

appropriate treatment. In the first part of their book the authors have presented a discussion of the evolution of interviewing techniques and, in evaluating the changes, have clearly demonstrated the shift in emphasis "from diagnosis to treatment, from information gathering to the fostering of an optimal therapeutic climate, from concern with the facts elicited to concern with the nature of the patient-therapist interaction."

The authors present four major determinants in knowing and understanding the dynamics of the process of interviewing, namely: 1) the personality structure of the two participants, 2) the way in which they view their own and each other's roles, 3) the purposes that each is pursuing (both conscious and unconscious), and 4) the technique which the interviewer employs. This interpersonal relationship in the therapeutic situation has been described by H. Kelman as a bipolar unitary process where doctor and patient are "constantly and continuously mutually and reciprocally influencing one another."

Every experienced analyst will appreciate the author's stress on the need to respond to more than the verbal communications of the patient, to be alert to what is included and what is excluded, to give weight to the doctor's initial impressions and intuitive feelings and to formulate tentative objectives or goals. They discuss three main aims of the interview: to establish rapport between the doctor and the patient; to appraise the patient's psychiatric status in regard to the nature of his illness, his motivation for therapy, his capacity for therapy, and external factors helping or hindering the undertaking of therapy; and to reinforce the patient's wish to continue therapy and plan with him his future steps in this direction.

Recent workers, studying recorded interviews have revealed that listening to the sound track is far superior to reading a transcript of a meeting. One quickly recognizes the relative neutrality of a script as compared with the richness of the disc or tape which conveys "timing, intensity and emphasis, as well as modulation of the voice." It also permits detection of nagging, whining, pleasure, arbitrary rightness, pomposity, deadness, hostility, calm, or anxiety. In addition the analyst has a chance to evaluate critically his performance and to compare his actual behavior with his preconceived image of how he behaves. His reaction to this exposure to himself, alone or in the presence of his colleagues, can be a most valuable personal experience.

Courses, lectures, and the study of recordings of interviews have many aims. One outstanding and highly desirable goal is to enable an analyst to become more effective as a therapist. In her courses on technique, Horney stressed wholehearted concentration, which included unlimited receptivity and "being there" with the patient with all of one's feelings and reasoning. She further emphasized comprehensive observation and interpretation by seeking essentials. Knowing more and more about the how, the what and the when of the problem enabled the therapist to avoid premature, selected and limited remarks. Finally she indicated that a productive tapping of one's own resources, such as spontaneous feelings, flash thoughts, personal associations, and so forth, would lead to richer relating and interpreting. If one considers his use and abuse of these principles while listening to a playback of an interview the experience can be meaningful both on an interpersonal and intrapsychic level.

The second part of this work consists of the transcript and discussion of three interviews. Two were conducted by experienced therapists and the third by a junior medical student. Particularly with the latter, the authors point out how intrusions of one's own personality in the form of moralizing or selecting and excluding areas through inner needs and difficulties, and premature interpretations or questions all add further complications to an already complex working relationship.

One proposal of the authors, open to criticism, is that of giving up the collection of historical data. Even the authors feel they may be "trying to push too far." At present they believe that therapists will have to free

themselves from even "the remnants of the medical and psychiatric tradition with its inventory of fact and feeling" in order to avoid "fact-gathering." They further note that fact-gathering is often resorted to by an anxious or perplexed interviewer as a security measure. At best they consider it useless or wasteful and at worst harmful to the relationship and the progress of the interview.

It is true that "just asking for facts" can serve to fill neurotic needs, but it must also be recognized that certain patients come to the doctor with great difficulty in verbal communication. Moving into and building up the relationship by means of questions and answers may give them time to get their bearings, to think about themselves, and to recognize the interest of the doctor in, and the importance of revealing, all areas of their lives.

On listening and becoming involved in these interviews one finds oneself, at times subtly and at time abruptly, now feeling with, now differing from the therapist and the patient, as a sort of participant observer once removed. The nuances of the interpersonal experience are available for detailed examination. This book with its records can be of great value for the psychiatric resident and can be a stimulating and provocative experience for the psychoanalyst and is highly recommended.

—Norman J. Levy, M.D.

ANNUAL REPORTS: 1954-1955

The Association for the Advancement of Psychoanalysis

During the past year the Association has continued to fulfill its specific aims and functions through its varied organizational programs.

The scientific program organized by the Association included: papers of theoretical and clinical interest to the profession presented at the New York Academy of Medicine monthly, and papers given at the monthly Interval meetings for the candidates of the Institute and the membership. The subjects in the latter group covered specific problems in therapy as well as reports and discussions on trends in other psychiatric meetings. At two of the meetings in the latter group, candidates made the presentations.

Another function of the Association, the Annual Karen Horney Lecture, was presented at the New York Academy of Medicine on March 23, 1955. This lecture was preceded by a dinner in honor of the speaker of the evening, Dr. Kenneth E. Appel. Both events were well-attended.

At the meeting of the American Psychiatric Association in Atlantic City, the Association organized and presented a Round Table Discussion on "Goals in Therapy." The members of this panel included Dr. Harold Kelman as moderator, and as participants from the Association, Drs. Elizabeth Kilpatrick, Alexander R. Martin and Frederick A. Weiss. Other participants were: Drs. Nathan Ackerman, Oscar Diethelm, Rudolf Dreikurs and Frederick C. Redlich. The dinner which preceded the panel discussion and the panel itself were successful from a social and progressional standpoint. Many psychiatrists contributed from the floor and enthusiasm for the subject and presentation was expressed.

The American Journal of Psychoanalysis, published by the Association, has been increased to two issues a year. Vigorous promotion and interest have resulted in wider circulation and the establishment of a large list of regular subscribers from psychiatric hospitals and institutions, psychiatrists and psychologists. The July, 1955, issue of *Psyche* (published in German) reprinted Dr. Harold Kelman's article on "The Use of the Analytic Couch" as well as a condensation of Dr. D. Ewen Cameron's lecture on "Karen Horney: A Pioneer in the Science of Human Relations."

The Association continued to support and cooperate with the Auxiliary Council to the Association in its program of community education. Efforts in the past year were in the direction of consolidating the membership in the Auxiliary and presenting discussion groups instead of seminars, particularly for the membership at its repeated request. Four lectures were given to the public: The Experience of Growing Up —(Drs. Norman J. Levy and Bella S. Van Bark); Searching for Acceptance—(Drs. Helen Boigon and Milton M. Berger); The Meaning of Intolerance—(Drs. Melvin Boigon and Sidney Rose); and What Happens in Group Analysis—(Drs. Louis Landman and Eleanor Crissey). Five discussion groups were held for the membership on the following subjects: The Challenge of Marriage (Dr. Abe Pinsky); The Challenge of Living Alone (Dr. B. Joan Harte); Parents—The First Teachers (Dr. Gerard T. Niles); The Creative Later Years (Dr. Eleanor Crissey), and A Psychoanalyst Looks at History (Dr. Charles R. Hulbeck). In addition, as a contribution to National Mental Health Week, the Association cooperated with the Auxiliary in giving a public lecture on May 5, 1955, on the subject of "Is Human Nature Inherited?" Drs.

Bella S. Van Bark and Frederick A. Weiss participated in this event. Membership in the Auxiliary has continued on a high level, with a good spirit of participation.

Associate and Full membership in the Association has increased in the past year. The Association cooperates with the Karen Horney Foundation and members are working in the Karen Horney Clinic. Members also have given lectures at state hospitals and to scientific societies. They have also attended International Meetings abroad. Dr. Benjamin J. Becker's contribution on "Karen Horney's Observations on Transference and Countertransference" was published in the 1955 report of the International Congress of Psychotherapy on its meeting the previous year in Zurich. Dr. Dominick A. Barbara's book on *Stuttering* was published by Julian Press, Inc., in 1954.

—Bella S. Van Bark, M.D.
President

AMERICAN INSTITUTE FOR PSYCHOANALYSIS

BOARD OF TRUSTEES

So far, this year has been an ever-increasing move toward greater consolidation and integration. Individual initiative has been blending more with group decision. Neither the individual nor the group has lost its identity by the blending. The birth of the Karen Horney Clinic has become a fact.

The Board of Trustees has met ten times. In addition, it has had two joint meetings with the Board of Directors of the Karen Horney Foundation.

On June 8, 1954, the first joint meeting of the combined Board of the American Institute for Psychoanalysis and the Karen Horney Foundation, was held. Many questions of mutual interest were discussed. These were clearly formulated and referred back to their respective Boards for study and consideration.

At the June 16 meeting, the Board of the American Institute for Psychoanalysis approved a statement of appreciation regarding Dr. Elizabeth Kilpatrick's service as Dean, to be sent to the *Journal*. This statement has been published in the current issue of *The American Journal of Psychoanalysis*.

Dr. Louis E. DeRosis was certified at the September 9 meeting. Dr. Kilpatrick, Chairman of the Karen Horney Technique Committee, reported that favorable initial progress was being made on the project to publish individual lectures on technique in the *Journal*. These articles are to be based on Dr. Horney's own presentations in her Technique Courses. The resignation of Dr. Norman Kelman from the Board was accepted with regret.

On September 29 a continuation of the September 9 meeting was held. Suggestions and answers to questions raised at the joint meeting of the Karen Horney Foundation and the American Institute for Psychonalysis were approved and submitted to the Foundation for their consideration.

It was decided to hold a Dean's Reception on October 10. This function was successfully held and enthusiastically attended.

The recommendation of the Faculty Council to start Extension Courses in Spring, 1955, was approved.

A retirement plan for the Registrar, Miss Janet Frey, was officially approved.

At a meeting October 13 it was decided to publish a news letter to be sent to the candidates. The Faculty Council was delegated to assume this responsibility.

On October 24 a Membership Meeting was held. The President's report was given by Dr. Harold Kelman, and the Dean's report by Dr. Kilpatrick.

The Membership Committee reported there were four members, ten associate members and fifteen auxiliary members. This meant an increase of seven associate members and a decrease of six auxiliary members.

Dr. Joseph W. Vollmerhausen was certified at the November 10 meeting. The vacant seat on the Board of Trustees was filled by the election of Dr. Vollmerhausen. At the December 15 meeting Dr. Lester Shapiro and Dr. Louis Murillo were certified.

At the January 19, 1955, meeting, Dr. Paul Lussheimer was nominated for appointment to Clinical Directorship of the

Karen Horney Clinic. Dr. Louis R. Hott was appointed as assistant to the Clinical Director.

The following were elected as members of the Medical Board of the Karen Horney Clinic:

Dr. Nathan Freeman
Dr. Harry Gershman
Dr. Isidore Portnoy
Dr. Sara B. Sheiner
Dr. Bella S. Van Bark
Dr. Joseph W. Vollmerhausen
Dr. Frederick A. Weiss

At the February 9 meeting, the members of the Medical Supervisory staff of the Karen Horney Clinic were requested to state their available time to the Clinic. Further questions of mutual interest and suggestions were submitted to the Karen Horney Foundation.

On February 10 the second joint meeting between the Boards of the Karen Horney Foundation and the American Institute for Psychoanalysis was held. Necessary changes were made in the memorandum of understanding, giving responsibility for medical staffing to the Institute.

Qualifications for the Medical Staff were decided as follows: Members must be Medical Doctors, have a New York State license to practice medicine, have at least one year medical interneship in an A.M.A.-approved hospital, have at least one year psychiatric residency in an A.M.A.-approved hospital.

In addition, the qualifications for the special categories of the staff were approved:

Clinical Assistants: two years in practice of psychiatry and psychoanalysis.
Associates: five years in practice in psychiatry and psychoanalysis.
Adjuncts: seven years in practice in psychiatry and psychoanalysis.
Attending: eight years in practice in psychiatry and psychoanalysis and certified by the American Institute for Psychoanalysis.
Assistant to Clinical Director: eight years in practice in psychiatry and psychoanalysis
Director: Certified by the American Institute for Psychoanalysis and ten years practice in psychiatry and psychoanalysis

At the March 9 meeting the Karen Horney Foundation communicated that it had signed a five-year lease on the building at 115 East 31st Street, for the Clinic, and all appointments of the Medical Board were made as nominated by the Board of Trustees.

The final copy of the memorandum of understanding between the Karen Horney Foundation and the Institute was presented and officially approved.

The Board approved the qualifications of the Clinic Medical Board as psychoanalysts certified by the American Institute for Psychoanalysis, with at least eight years in the training and practice of psychiatry and psychoanalysis.

Dr. Freeman was appointed provisional supervising analyst. Dr. Louis Azorin was certified.

The list of categories of lecturers, associate lecturers, and assistant lecturers was approved.

Pertinent material on the clinic was approved for insertion in the 1955-56 curriculum.

The questions regarding amendment of by-laws was referred to the Membership meeting for clarification.

At the April 20 meeting matters of the Karen Horney Clinic were discussed and several recommendations to the membership were submitted.

On April 24 the Board appointed Dr. Lussheimer a training analyst. Its recommendation that he be elected a member was approved at the annual membership meeting which followed.

At this meeting the following gave their interim annual reports: President, Treasurer, Dean, Membership and Grievance Committees. Drs. Harold Kelman, Elizabeth Kilpatrick and Isidore Portnoy were elected trustees for terms of three years. Dr. Lussheimer was elected Chairman of the Grievance Committee and Drs. Portnoy and Vollmerhausen members—all for a term of one year. Dr. Wanda Willig was elected Chairman of the Membership Committee

and Drs. Ada C. Hirsh and Sidney Rose members—all for a term of one year. The membership approved the election of five members, sixteen associate members and nine auxiliary members. Total: 30.

At the reconvened Board meeting the following were elected: President, Dr. Freeman; Vice-President, Dr. Harold Kelman; Treasurer, Dr. Weiss; Secretary, Dr. Sara B. Sheiner, for terms of one year. Dr. Harold Kelman was appointed Dean for a term of three years. His recommendations were approved that Dr. Kilpatrick be appointed Associate Dean and that Dr. Portnoy be appointed Assistant Dean, both for a term of three years. Drs. Weiss and Alexander R. Martin were appointed to the Faculty Council for terms of two years.

At its May 18 meeting the Board approved the following recommendations: The Medical Board of the Karen Horney Clinic: that the following be appointed for a term of one year as staff members of the clinic:

Attendings: Drs. Freeman, Hirsh, Portnoy, Sheiner, Van Bark, Weiss

Adjuncts: Drs. Azorin, Gershman, Hulbeck, Loeb, Metzger, Vollmerhausen, Willig

Associates: Drs. Barbara, Berke, H. Boigon, M. Boigon, Cantor, Chirico, Clemmens, Crane, Edelstein, Franklin, Gottfried, Harris, Harte, Isenberg, Koblentz, Landman, Langer, Lipton, C. Miller, J. Miller, M. Miller, Mischel, Pisetsky, Rosenthal, Rubins, Schattner, Sharoff, Shulman, Slater, A. Symonds, Zimmerman.

Clinical Assistants: Drs. Bernath, Canelis, Fischer, Horner, Padoussi, Passoni, Rawitz, Safirstein, Seitz, M. Symonds, Willner.

Acting Consultant Neurologist: Dr. Geoffrey F. Osler.

—NATHAN FREEMAN, M.D.
President, Board of Trustees

THE DEAN

It is our continuing desire to find ways of improving our training program and to select candidates who could benefit most from it. Toward that end procedures have been instituted and changed. Some are of long standing and others are more recent. They are the outcome of our attempt to learn from our previous experiences.

Among these policy changes is our tendency to become more rigorous in our admissions procedures, requiring more frequently, in the past year, a Rorschach test. Also, to obtain a diversity of opinion, the membership of the Admissions Committee has been rotated through the Faculty Council. The personal analysis of each new candidate, once accepted, is reviewed at the end of three and again after six months. Such discussions have not only been informative to the Faculty Council but also of benefit to the training analyst and in turn the candidate with whom he was working.

We are also encouraging training analysts to bring to the attention of the Faculty Council candidates whose progress is dubitable at any time during their training. Also, the total progress in training of all candidates is discussed, after a candidate's interview with his Faculty Adviser, when his advancement to senior status is being considered. The requirement of having three patients in treatment, for a minimum of three times weekly, as a requirement to senior status, has led to an increased experience and interest in analytic therapy. It has made for more fruitful work in supervision and has improved the quality of presentation in clinical courses as well as in class participation. The detailed reports on supervision have helped in evaluating a candidate's progress. As a result the number and spacing of supervisions has been more adequately timed to coincide with the rhythm of a candidate's development.

In order to help candidate and training analyst experience the analytic work more as a mutual therapeutic venture, the Faculty Adviser system was instituted. The candidate is encouraged to discuss with his Faculty Adviser any questions regarding the didactic aspects of his training program. He is also informed of Institute policies through the Information for Candidates,

which is revised from time to time. The long-standing policy of being supervised by an analyst other than his personal analyst is continued. As an expression of this same attitude, no candidate instructs in any course which his personal analyst conducts. By the Fall of 1957, we hope to have a teaching staff without candidate personnel. This clear separation of personal analysis and administrative problems we feel will help candidate and analyst devote themselves more wholeheartedly to the task of the candidate's personal growth and development.

As more candidates come up for certification, we are having an opportunity to evaluate our admissions procedures and the results of our whole training course. Our more rigorous admissions policy I have mentioned. From experience we have found that incentive for self-investigation, awareness of personal problems, an interest in and feeling for human beings in distress and a genuine wish to help them are of crucial importance in an applicant's personality. Although we feel that all have grown as human beings and are effective practitioners of psychoanalysis, we see areas for improvement. We have noted a tendency, particularly in the final case presentations, to do much theorizing, intellectualizing, and explaining. Although we have emphasized the importance of the doctor-patient relationship in therapy, of the symbolic and of feelings, more effort will be made to communicate their importance in all aspects of our training program.

In keeping with our main thesis that human beings can continue growing as long as they are living, we offer a variety of opportunities for such further development in the form of further personal analysis and supervision, participation in post-graduate seminars, and participation in the teaching program. Some have the additional advantages that come from becoming training and supervising analysts and from the discussions with the Faculty Council and colleagues participating in this important work. And, finally, all are encouraged to go on with their self-analysis concomitantly with personal analysis.

In January of the past year the Institute began including Extension Courses in its curriculum. They have proved of such value that next year they will be given in both semesters. It is our hope to expand this program and to create an Extension Division. Through it we will be more able to communicate our ideas to people working in allied fields and to groups wanting to avail themselves of our help for their particular area of interest.

With the opening of the Karen Horney Clinic in May, new areas of cooperation and expansion will be added to the Institute's training program. The therapy of patients, the superivision of such work, and clinical seminars will become an integral of our curriculum.

It is now more than two years since Dr. Horney died. With this report she would have been completing her term of office as Dean to which she was appointed in April, 1952. We hope we have carried on in the spirit for which she stood: the spirit of helping human beings to live fuller lives, of helping to train better therapists, and of helping to advance psychoanalysis.

—HAROLD KELMAN, M.D.

Candidates' Association

The underlying theme of the program of the Candidates' Association this past year has been increased integration and mutual understanding among the various groups comprising the American Institute for Psychoanalysis. Basic to this cause was the important committee formed to ascertain candidates' attitudes and feelings toward the Institute and its functions. Consequently, a meeting between the Association and the Institute was convened at which time both participants shared the satisfaction and realization of each other's aims and goals, indeed an unique and democratic experience.

Notable among the achievements of our tenure was the Association's wholehearted support of the newly formed Karen Horney Clinic toward which was pledged our financial aid and candidates participation in the clinic program.

A contribution was made towards the American Psychiatric Association Building Fund, memorializing Karen Horney as a member of the Century Club.

In matters of organization, meetings were streamlined. The program gave half the time to procedural business, the remainder to a discussion of various practical problems occurring in treatment, such as how to manage depressive reactions, suicidal threats, and the like.

A revision of the referral system was undertaken, and the possibilities of group-sponsored malpractice benefits explored. The Bulletin staff was increased and more scientific material reported. As in the past, many of our members were active in courses at the New School, the Institute, and in connection with the program of the Auxiliary Council to the Association for the Advancement of Psychoanalysis.

Socially, our annual dinner in May fostered the group's spirit of friendship and cooperation, as did the summer picnic at Stony Lodge. Over-all the year saw much in personal and collective growth and development, with a sincere feeling of accomplishment and satisfaction.

—Louis R. Hott, M.D.
President

The American Journal of Individual Psychology

6 North Michigan Avenue, Chicago 2, Illinois

Rudolf Dreikurs, M.D., Editor

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